University of Alberta

A Prospective Policy Analysis of the Elimination of the Exclusive Scope of Practice From the Nursing Profession Act

by

Doreen Reid ©

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of
the requirements for the degree of Doctor of Education

in

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled **A Prospective Policy Analysis of the Elimination of the Exclusive Scope of Practice From the Nursing Profession Act** submitted by Doreen Reid in partial fulfillment of the requirements for the degree of Doctor of Education in Educational Administration and Leadership.

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DEDICATION

This work is dedicated with great love and appreciation
to four people,
two of whom have preceded me and two of whom will succeed me:

Margaret Roberts
(1912-1996)
my mother,
who taught me that learning is a life-long process
and was a model of love and everlasting support and encouragement;

Walter Roberts
(1912-1998)
my father,
who taught me about patience and grace
and was continually interested in and supportive of my every endeavor;

and

Randi and Terri-Anne
my daughters,
in the hope that
they will be challenged to pursue continuous learning
as the most important and cherished investment they can make
in themselves as they travel life's journey.

ABSTRACT

This study consists of a prospective policy analysis of the issue of eliminating the exclusive nursing scope of practice from existing health profession legislation. The intents of the study were to describe the historical background and present status of the public policy issue of eliminating the exclusive practice clause from the Nursing Profession Act in Alberta; to explore the desirability and feasibility of eliminating this clause as one means of working towards decreasing barriers between health profession groups; to identify alternative approaches or policy solutions to the proposed legislative change acceptable to stakeholders; and to provide recommendations for policy formation based on thesis findings.

This study was conducted as a qualitative case study, utilizing a conceptual model which incorporates Dunn's (1981) Model of a Policy System. Data collection occurred through semi-structured interviews and document and literature review. Fourteen participants, representing the nursing profession, the licensed practical nurse profession, the Departments of Labour, Health and Advanced Education and Career Development, and members of the public were included in the study. Content analysis and comparative analysis procedures were used in analysis of both the document and interview findings. Categories for data reporting and analysis were developed based on the conceptual framework and the research questions.

Measures to ensure validity and reliability of the study included triangulation, external audits, and provision of detailed descriptions of the context of the study, stakeholder perspectives, and the research processes. Recommendations unfolded as context-bound reflections evolved from an in-depth understanding of the issues rather than a series of generalizable truths or theories. Formal consent to use the interview data and assurance of anonymity and confidentiality other than as specifically approved by the interviewee were the major measures used to address the ethical concerns.

There are several major conclusions from this study. First, the elimination of exclusive scopes of practice from health profession legislation in Alberta is a significant policy issue. Second, the central tenant of professional regulation has always been, and remains the protection of the public from potential harm incurred by incompetent or unethical practitioners. Third, exclusive nursing legislation has been regarded by the nursing profession as the ultimate symbol of success in the achievement of professional status and is not perceived by nurse leaders to be restrictive of service delivery by other professions. Fourth, the existing model of health profession legislation characterized by exclusive professional jurisdictions is not in keeping with the contemporary need for more flexible scopes of practice which recognize that different types of competent practitioners may provide the same health services.

Two policy implications were evident from this study. First, greater emphasis on professional competency was perceived to be a more viable alternative to protecting the public interest than the pursuit and protection of exclusive jurisdictions. Second, without alternate models of remuneration, it was predicted that there would be little change in relation to the provision of professional services.

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Although this research experience has been the highlight of my career, it would not have been possible without the willing participation, direct involvement and support of others.

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I owe a great debt of gratitude to my family, without whose support it would not have been possible to undertake this doctoral program. My husband bore the brunt of employment responsibilities in order that I could focus on my goal. He also 'grounded' me, or more wisely, corrected all computer glitches and willingly managed many pages of printing. Our children were subjected to a few 'tales of woe,' always providing their own most thought provoking insights and support. It will be a joy for them to have an affirmative answer to "Are you done yet?"

And, in the final analysis, it has been the collectivity of personal and financial support that has made this experience as a doctoral student the highlight of my career. As I reflect over the past three years, it is with some sadness that I draw this most personal and rewarding experience to a close, for I have had the opportunity and the support to pursue my scholarly ambitions in a way which many can only dream of. I have, indeed, been very privileged.

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CHAPTER 1

OVERVIEW OF THE STUDY

> Any searching examination of privilege is unwelcome. Privileged groups are naturally aggrieved; from their point of view, privilege, once gained, is best forgotten. The professions operate in an atmosphere of almost sacerdotal reverence: the stillness of the courtroom, the antiquity of the solicitor's office, the silence of the doctor's surgery. How unseemly to apply . . . analysis to all that! (Lees, 1966, p. 4)

Unseemly, or not, the regulation of professionals has become a controversial and critical issue in society today. Until recently, the growth of health professions and the corresponding increase in self-regulating licensure have been subject to a public policy stance of benign neglect (Young, 1988). For half a century the traditional professions have enjoyed relatively uncritical public esteem, significant influence on legislation, and economic rewards less dependent on the marketplace than other occupations (Ostry, 1978; Freidson, 1983). Licensing of professionals has been accepted as a necessity to protect the public health and safety of uninformed consumers; its social value has seldom been questioned. While there has been historic concern over the monopolies of professional services, it is only recently that the uncritical acceptance of professional self-regulation has been questioned (Lomas and Barer, 1986; Light, 1988).

Understanding the extent and types of occupational regulation requires that we distinguish among three forms of legislative policy. Occupational regulation appears in provincial statutes in three forms (Young, 1988). The simplest form of regulation is *registration*, which requires an individual to be listed on an official roster. *Certification* is acquired once an individual has graduated from an approved training program, completed related work experience, passed qualifying examinations, and provided proof of good moral character. Certification frequently limits the use of a title, but does not restrict others from engaging in a given occupation. The more sought after and rigorous of regulations is *licensure*, which requires qualifications similar to certification but prohibits others from practising within an occupation without a license. It is this latter regulation which is the focus of this policy issue.

In Canada, many of the health professions have been delegated legislative authority for a system of self-regulation that substantially influences who may provide service, the manner in which service is provided, who may receive service, and the nature of the service received (Rose, 1983). In Ontario, at least twenty-four health professions have achieved some measure of self-governance (Health Professions Legislation Review, 1989). In Quebec, twenty-one health occupations have exclusive practice restrictions or reserved titles (Contandriopoulos, Laurier, & Trottier, 1986). Currently in Alberta, public policy regulates 29 health occupations. Fourteen of the health professions, e.g., medicine, nursing, physical therapy, have free standing statutes. Eight of these statutes provide the respective profession with exclusive legislation prohibiting practice without a license. Fifteen professions are governed by an umbrella statute with right-to-title legislation (Alberta Health Workforce Rebalancing Committee, 1994).

Since the late 1970s, several factors have come together to bring about an emerging public policy focus on the regulation of health professionals: rising health care costs, increasing consumer demand for choice in health service and participation in policy development and charges of professional self-interest and monopolistic practices (Hogan, 1983; Light, 1988; Young, 1988; Coburn, 1993; Boase, 1994; Manitoba Law Reform Commission, 1994; Pew Health Professions Commission, 1995; Sutherland, 1996). Critics claim that professional regulations have not ensured quality service, licensing boards have failed to discipline unethical practitioners and actions against the unlicensed limit competition, not incompetence (Rottenberg, 1980; Carroll and Gaston, 1983; Derbyshire, 1983; Gross, 1988). In particular, licensing laws increase the cost of professional services, increase practitioner income, limit practitioner mobility, create manpower shortages and ineffective use of paraprofessionals, and impede needed reform in training processes, service provision, and payment structures (Ostry, 1978; Kleiner, Gay, & Greene, 1982; Lomas and Barer, 1986; Young, 1988; Manga, 1993; Manitoba Law Reform Commission, 1994; Pew Health Professions Commission, 1995; Sutherland, 1996).

Proponents of regulation, namely professionals, argue that in order to protect the public, it is necessary to prevent unlicensed persons from engaging in any aspect of the licensed occupation. Professional groups have been wary of government attempts to revise professional practice legislation long considered cornerstones which define a professional body and ensure safe and ethical practices to a public generally unable to evaluate health services (Trebilcock, 1978; Dussault, 1986; Coburn, 1993).

Over the past three decades, at least four Canadian provinces have introduced significant changes to health profession legislation. In Ontario, the Commission on Civil Rights (1968) undertook a review of procedural and administrative issues pertaining to all self-governing professions. Two years later, a Quebec Commission of Inquiry on Health and Social Welfare released the Castonguay Report (1970), noteworthy in its attempt to increase government and public involvement in the regulation of professions. The resultant *Quebec Professional Code*, enacted in 1973, reflected a 'moderated self-regulation of the professions' and became a model for future professional legislation in Quebec (Castonguay, 1978). In Ontario, the Committee on the Healing Arts (1970) examined many aspects of the regulation of the health profession, culminating in umbrella legislation under the *Health Disciplines Act* in 1974. The Ontario Health Professions Legislation Review was established in 1982 in response to a series of concerns surrounding existing provincial legislation. A decade-long review process culminated in the passage of the *Regulated Health Professions Act* in 1991 which captured the interest of other provincial governments. In 1990 the Government of Manitoba established the Manitoba Law Reform Commission to initiate a review similar to that undertaken in Ontario. A final report, released in 1994, expressed many of the same principles inherent in the review in Ontario (Manitoba Law Reform Commission, 1994).

Beginning in 1972, the Government of Alberta undertook a series of activities with the appointment of the Special Committee of the Legislative Assembly of Alberta on Professions. The resultant Chichak Report provided a series of recommendations related to future health profession legislation in Alberta. A policy paper in 1978 largely reiterated the recommendations of the Chichak Report. In 1984 the enactment of the *Health Disciplines Act* enabled groups of professions pressing for recognition to be governed under this single statute with right-to-title legislation. In 1994 the Alberta Health Workforce Rebalancing Committee was established by the Ministers of Health and Labour to review existing health profession legislation. In the same year, a controversial *Health Professions Act*, similar to the *Regulated Health Profession Act* in Ontario, was proposed and continues to be discussed with health profession groups. In both of these statutes, all exclusive practice clauses contained in free-standing statutes were eliminated and replaced with a list of 'restricted activities' (Ontario Health Profession Review, 1990; Alberta Health Workforce Rebalancing Committee, 1994). It is the elimination of the exclusive scope of practice clause from the Nursing Profession Act in Alberta which is the subject of this research study.

Despite the proliferation of commissioned reviews and policy papers, professional groups have successfully thwarted any serious attempts to alter the practice of health professionals or the relationships between professional groups (Contandriopoulos et al., 1986; Dussault, 1986; Tuohy, 1986; Boase, 1994). Regulatory changes have largely focused on the structures and processes of professional regulation, providing for lay representation on professional governing councils, cabinet approval of regulations, and mechanisms of appeal by nonmembers regarding decisions of professional bodies.

However, these changes have had little effect on the allocation of functions among health care personnel (Lomas and Barer, 1986; Tuohy, 1992; Boase, 1994; Sutherland, 1996).

The most recent framework for professional legislation, implemented in Ontario and proposed in Alberta, represents a radical departure from the traditional occupational-based model of health profession legislation to a task-based model. This shift in focus has been acclaimed by policy-makers as providing the means for greater regulatory flexibility than has been possible in traditional legislation (Health Professions Review Committee, 1989; Alberta Health Workforce Rebalancing Committee, 1994; Manitoba Law Reform Commission, 1994). At present, this claim is unsubstantiated until this model of health profession legislation is fully operationalized and evaluated.

Any single model of professional regulation is unlikely to attract consensus amongst key stakeholder groups. Inevitably, formation of public policies directed at the professions will result in collectivities of diverging interests (Trebilcock, 1978). The question is not whether there will continue to be professional regulation and control; instead, the question is one of balance and degree. As controversies over the regulation of the health professions persist and indeed heighten, the outcome of this research study is intended to focus the issues and inform the debate.

PURPOSE OF THE STUDY

The purpose of this study was to conduct a prospective policy analysis to determine if eliminating the exclusive practice clause from the *Nursing Profession Act* is a feasible policy solution to the perceived need to eliminate barriers to the provision of professional services, or if other solutions are more desirable and feasible. The study describes the historical background and present status of the public policy issue of eliminating the exclusive practice clause from the *Nursing Profession Act* in Alberta; stakeholders' perceptions of the desirability and feasibility of eliminating this clause as a means of decreasing barriers between health profession groups; and the desirability and feasibility of alternate mechanisms or policy solutions to the proposed legislative changes. Reflections on policy formation were developed from the findings.

RESEARCH QUESTIONS

The study addressed the following questions and sub-questions:

1. What is the history of exclusive scope of practice legislation as applied to nurses and related paraprofessional groups in Alberta?
    a. When did exclusive scope of practice legislation first become a policy issue?
    b. Who promoted exclusive scope of practice legislation and why?
    c. Historically, what have been the expressed positions of stakeholders in relation to exclusive practice legislation and why?
2. Is the proposed strategy to eliminate exclusive practice legislation a feasible or desirable policy to remove barriers to delivery of services?
    a. Is there a need to increase access to service delivery?
    b. What factors are contributing to the increased demand for changes in legislation?
    c. What are the expressed positions of various stakeholders?
    d. Why do stakeholders hold these positions?
3. What alternatives to the proposed legislative changes do stakeholders perceive as desirable and feasible ?
    a. To what extent do stakeholders support the proposed policy changes?
    b. Are there other policy solutions which could resolve this issue?
    c. Why do stakeholders hold these positions?
    d. What factors affect resolution of this issue?

SIGNIFICANCE OF THE STUDY

The present study can be justified on scientific, professional and political grounds. First, health profession legislation, from an economic, political, and social perspective, is a current and controversial issue in every Canadian province, having gained the attention of policy makers and professionals. Second, the nursing profession is the largest group of licensed health personnel in Canada, augmented by at least two paraprofessional groups i.e., licensed practical nurses and nursing aides, which are directly linked to the professional group. Third, changes to nursing legislation have occurred gradually over the past fifty years, often amidst considerable debate. Fourth, the changes that are proposed to the Nursing Profession Act are identical to those proposed for eight other health professions with exclusive practice regulations and similar to seven other health professions that also have free-standing non-exclusive legislation. Therefore, through the description of the stakeholder perspectives on this issue, and the identification of potential solutions, representatives of health professionals and the Departments of Alberta Health and Alberta Labour should be assisted in future policy development and long-range planning.

RESEARCH FRAMEWORK

This study was designed as a qualitative case study of public policy issues involved in the proposed changes to health profession legislation in Alberta. The key stakeholders were defined as representatives of: the nursing profession, licensed practical nurses, the Departments of Alberta Health and Alberta Labour, and the informed public. A model for prospective policy analysis was developed which utilized Dunn's (1981) Model of a Policy System.

Data were gathered by semi-structured interviews and document analysis. Data analysis procedures incorporated content analysis and comparative analysis methods. The scholarly reflections were based on an analysis of documents, literature and participant interviews. Specific recommendations regarding policy-making in relation to health profession legislation are described.

ASSUMPTIONS

The major assumption of this study is that the proposed elimination of the exclusive scope of practice clause from the Nursing Profession Act is an important issue in the political context of future legislative changes.

A second assumption underlying this study is that the information obtained from stakeholders and documents are the most valid sources in determining the background to the issue, perceptions of the issue, and key factors related to resolving the issue.

A third assumption is that participants will recall and report as accurately as possible, events and perceptions which are central to the study.

DELIMITATIONS

This study is delimited by the fact that it is focused in Alberta on one health profession, and on one proposed change to existing legislation. Therefore, it must be interpreted within that prevailing political and socioeconomic context.

Secondly, the focus of this research is on one political issue. The perspectives on circumstances surrounding the proposed legislative change and the feasibility of policy alternatives may have applicability to other similar policy issues. However, no such generalizability can be claimed with certainty.

LIMITATIONS

The main limitations of this study relate to the reliance on a single researcher to collect and analyse available data. The small sample size and the selection of participants may influence the replication of findings.

Secondly, the perceptions of stakeholders, including the researcher as a member of one of the stakeholder groups, may be biased in relation to professional and organizational affiliations. Data obtained from interviews and documents may be presented in a manner which promotes a particular viewpoint.

Finally, all of the data relevant to the policy issue may not be available to the researcher because of intended or unintended omission.

DEFINITIONS

A number of common terms or phrases used in relation to professional health policy are defined as to their specific application in this study.

Discipline:	A profession or occupation with a recognized body of specialized knowledge or expertise; e.g., health disciplines, dental disciplines.
Exclusive scope of practice:	A statutory provision that limits the right to provide services to licensed members of a given profession or occupation. Exclusive scopes of practice can be narrow, as in the case of opticians' exclusive right to dispense eyeglasses, or broad as in the case of physicians' exclusive right to practice medicine (Alberta Health Workforce Rebalancing Committee, 1994, p. 30).

Free standing legislation:	An act, or statute, which governs a single profession; e.g., Nursing Profession Act.
Health profession association:	An association representing members of a health profession which has statutory responsibility for registration and discipline; e.g., Alberta Association of Registered Nurses (Alberta Health Workforce Rebalancing Committee, 1994, p. 31).
Licensed professionals:	Practitioners who are authorized by legislation to practice within the scope of practice of a named profession. Unlike the certification process, individuals who are not eligible to register with a professional association can not perform functions within the scope of practice of the profession (Gross, 1988, p. 5).
Occupation:	A group which may include a profession, trade or discipline.
Profession:	A selected group distinguished in status from an occupation on the basis of such factors as the level of education required of its members and the control its members exercise over the provision of services. The term, in most contexts, is used interchangeably with discipline or professional occupation (Alberta Health Workforce Rebalancing Committee, 1994, p. 31).
Public interest:	A phrase which broadly refers to the protection of all persons who are the recipients of health services,

	based on the assumption that the consumer of service does not have sufficient knowledge to judge professional practice. The phrase usually includes four aspects: (a) the public must be protected from unqualified, incompetent and unfit health care providers to the extent possible; (b) mechanisms must be in place to encourage the provision of high quality care; (c) the public should have freedom of choice within a range of safe health care options; and, (d) there should be scope of evolution in the roles played by individual professions, and flexibility in how individual professions can be utilized, in order that the health system functions with maximum efficiency (Ontario Health. Professions Legislation Review, 1989, p. 6).
Regulatory body:	A professional association or statutory board responsible through legislation for the registration and discipline of an occupation/profession.
Right-to-title legislation:	A form of legislation which restricts the use of a title to registered members of a professional group; e.g., registered nurse, licensed practical nurses. Individuals who are not registered may practise within the defined scope of practice of the profession but may not use the title reserved for the profession (Alberta Health Workforce Rebalancing Committee, 1994, p. 5).

Scope of practice:	A phrase which defines the practice area of a named profession. The statement or description generally includes what the profession does, the methods it uses and the intended outcome of its practice (Ontario Health Professions Review, 1989, p. 15).
Self-governance:	A privilege that is delegated by government through legislation to some professions; e.g., nursing, medicine, dentistry. These professions are then responsible to the public for carrying out a range of statutory functions; e.g., granting a license to practice, discipline of members (Alberta Health Workforce Rebalancing Committee, 1994, p. 31).
Stakeholders:	Individuals or groups who have a stake in policy or issue resolution because they affect and are affected by government decisions (Dunn, 1981, p. 60).
Umbrella act:	A single act which governs more than one professional group; e.g., Health Disciplines Act, Dental Disciplines Act.

ORGANIZATION OF THE THESIS

This study describes the perceptions and positions of key policy stakeholders in relation to whether the elimination of the exclusive scope of practice clause from the *Nursing Profession Act* is a feasible policy solution to the perceived need to eliminate barriers to the provision of professional services; explores possible alternative solutions and stakeholder responses to these solutions which may be more desirable and feasible; and provides reflections for policy formation based on the findings.

Chapter 2 establishes the general policy context for the study through review of the relevant literature. Policy analysis and policy research are discussed in relation to prospective policy analysis. The discussion of the policy system surrounding health profession legislation includes a description of the policy stakeholders, the policy environment and the public as consumers of health services. The issues which have arisen in relation to health profession legislation and the perspectives regarding the need, and the feasibility of reforming health profession legislation are explored. The second section of the chapter provides an overview of the process by which occupations achieve professional status and the changing conceptualizations of professions. The final section of the chapter provides a description of professional licensure as background to the emergence of professional regulation and exclusive practice jurisdictions.

Chapter 3 describes the conceptual framework, research design, and data collection and analysis procedures used in conducting the study. This chapter includes a description of the research process, the decisions made during the study, and the methods used to enhance the reliability and validity of the study.

Chapter 4 provides an historical and current overview of the policy context in Alberta. This chapter includes a discussion of policy papers which have been central to health profession legislation in Alberta. The final section of the chapter describes the policy context in Alberta following the appointment of the Alberta Health Workforce Rebalancing Committee in 1994 and the proposed *Health Professions Act*.

Chapter 5 describes the perspectives of the selected nursing participants.

Chapter 6 describes the perspectives of the government participants and the public representatives.

Chapter 7 provides a summary of the findings from the four groups of participants and identifies the commonalities and differences in perspectives. Possible alternative models or policy directions are discussed.

Chapter 8 summarizes the intent of the study and the circumstances which were operational as the study evolved. The final section of the chapter includes a collection of scholarly reflections presented in the form of an 'open letter' to each of three groups: the health professions, the nursing profession and government policy-makers. Within these reflections are embedded recommendations for further research.

CHAPTER 2

REVIEW OF THE LITERATURE

This chapter initially provides an overview and description of the field of policy analysis as a background to the development of the research framework utilized in the study. The second section includes a discussion of health profession legislation as a policy system. Based on Dunn's Model, this section includes a description of the key stakeholder groups, the policy environment and the health policies which have shaped the development of health profession legislation and provided the context within which the proposed elimination of the exclusive scope of practice clause from nursing legislation can be conceptualized as a public policy issue in Alberta. The third section provides an overview and description of the cluster of attributes thought to distinguish professions and the process by which occupations achieve professional status. A description of the more recent shift to an ideological focus on the social and economic aspects of professionalization concludes this section. The discussion is included to provide the background to issues which have evolved in relation to health profession legislation. The fourth section of the chapter provides a description of professional licensure as the central component in the achievement of professional self-governance and the delineation of exclusive practice areas. Included in this discussion is a brief historical perspective on professional regulation and the issues surrounding professional licensure. A brief summary of the literature review concludes the chapter.

POLICY AND POLICY ANALYSIS

A policy is a program of action or non-action pursued in response to a particular problem or issue, according to Jackson and Jackson (1988, p. 565). Nagel (1980) described a policy as a government decision with regard to ways of handling various problems generally considered to require collective rather than individual action. Tuohy

(1992) described a policy as a pattern of purposive actions typically involving a wide variety of efforts in which political institutions address societal problems. Many others have advanced similar descriptions (Easton, 1965; Lindblom, 1968; Lowi, 1970; Laswell and Kaplan, 1970; Dror, 1971a), engendering what Dye (1992) concluded was a futile attempt at defining the "proper" definition which diverts attention from the study of public policy itself (p. 3). In advancing what he considered to be a summation of earlier attempts, Dye concluded that a policy was simply whatever governments choose to do or not to do (p. 3).

Worth (1978) believed that policies "stemmed from ill defined goals, alternatives were frequently ignored, superior choices tended to give way to the acceptable, and careful data analysis was displaced by expedient interpretations" (p. 3). In his view, policy was apt to emerge from the interaction of groups and interests in a power relationship. Thus, policy formation involved a process of conflict management, enhanced by policy research which incorporated an understanding of the political aspects of the policy issue.

According to Dye (1992), policy analysis is concerned with "who gets what" in politics and "why," and "what difference it makes" (p. xiii). In terms synonymous with policy analysis, Majchrzak (1984) described policy research as the "process of conducting research on, or analysis of, a fundamental social problem in order to provide policy makers with pragmatic, action-oriented recommendations for alleviating the problem" (p. 12). Hogwood and Gunn (1984) defined policy analysis as the determination of characteristics of an issue and the organizational and political setting of the issue. In their view, policy analysis did not resolve conflicts or determine political priorities, but was particularly applicable to ill-defined problems where there were a number of actual or potential policy interests, and where the issue did not fit neatly into a single organizational responsibility (pp. 263-264). Dunn (1981) described policy analysis as "an applied discipline which used multiple methods of inquiry and argument to produce and transform policy-relevant information that may be utilized in political settings to resolve public problems" (p. 60). Dror (1971) defined the term policy analysis as "an approach and methodology for design and identification of preferable alternatives in respect to complex policy issues" (p. 3).

What was evident from these, and other preferential descriptions of policy analysis was the interchangeable nature of the terms policy analysis, policy research and policy studies. What was also evident was a primary concern with description rather than prescription. It was the descriptive nature of policy analysis, according to Dye (1992, p. 7) which encouraged scholars to explore policy issues through systematic inquiry. The implied assumption was that developing scientific knowledge about the forces shaping public policy, and the consequences thereof, was itself a socially relevant activity and a prerequisite to a prescriptive focus.

Despite the varied attempts to define policy analysis, the intended value was to provide information to decision makers by isolating and clarifying overt and covert issues, revealing inconsistencies in aims and efforts, and generating and translating new alternatives into feasible and practical outcomes. Kalisch and Kalisch (1982) claimed that the primary contribution of public policy research was the yielding of insights in regards to possible solutions, thus enhancing the knowledge and experiential database of decision makers. In their own view,

> By making information available and exposing hidden assumptions and value preferences, public policy analysis can widen the area of informed judgement and counter the purely subjective approaches of program advocates. . . . This prevents the mere expression of personal opinions with general statements, thereby raising the quality of public discussion. (pp. 91-92)

Such research can occur in a variety of ways including examination of individual policies to determine what policy makers intended to accomplish and what actually was accomplished, examination of the process of policy development and implementation, or through extrapolation of future societal needs and potential problems which will require policy development, and identification of potential policy solutions to these problems (Montgomerie, 1990). The latter form of policy research is generally called prospective policy analysis.

Prospective Policy Analysis

Prospective policy analysis, as a specific form of policy analysis, involves the production and transformation of information prior to initiation of policy actions (Dunn, 1981, p. 51). Such analysis describes and determines relationships between phenomena, and identifies policy alternatives and preferences based on quantitative and qualitative data analysis to form a basis for policy decisions (W. Williams, 1971; cited in Dunn, 1981, p. 51). Prospective policy analysis can include the use of such techniques as problem-structuring, forecasting, feasibility assessment, scenario writing, and recommendation of preferred alternatives (p. 363).

Dunn (1981) contends that policy structuring is the most critical phase of policy analysis, since policy analysts fail more often because they solve the wrong problem or create 'errors of the third type' (p. 109). Inappropriate solutions are typically generated for policy problems which are frequently so complex that they seem to defy systematic treatment. The formulation of a problem is heavily influenced by the assumptions that different policy stakeholders bring to a given problematic situation. While many stakeholders may agree on the broad definition of a policy problem, there is often disagreement about its scope, severity, and importance. Yet, it is the assumptions surrounding the policy problem which are "crucial to the understanding the different ways that common experiences are translated into disagreements about the actual and potential courses of government action" (p. 101).

Policy problems may rarely be decomposed into independent, discrete, and mutually exclusive parts. In fact, policy problems are generally whole systems of problems, or messes, as Ackoff (1974) aptly labeled them. Mason and Mitroff (1981) described the same phenomenon as characteristic of wicked problems. Perhaps somewhere between these two descriptors lies the true description of health profession regulation, which some might connote as a 'wicked mess.' Nevertheless, it was the multiplicity of complex policy problems that had the potential to generate "unanticipated consequences that may follow from policies based on the right solution to the wrong problem" (Dunn, 1981, p. 100). In addition, these systems of problems were largely characterized by the interdependence of subgroups wherein the properties or behavior of each subgroup had an effect on the properties and behavior of the whole group (p. 100).

Dunn (1981) claimed that the clarity of problem definition was dependent on the complexity of the problem and the degree of interdependency of the issues. Well-structured problems reflected stakeholders who were in agreement with the goals and policy alternatives. Moderately structured problems were those involving a small number of decision makers, with a limited number of uncertain policy alternatives. However, the majority of policy problems were ill-defined and reflective of conflicting goals, objectives and alternatives. Accordingly, since policy makers were frequently unable to define the nature of the problem, or predict the range of positive and negative consequences associated with each policy alternative, Dunn (1981) warned that there was a tendency to choose a course of action which differed only marginally from the status quo (p. 106).

Health Profession Legislation as a Policy System

According to Dunn (1981), policy analysis takes place within an integrated policy system comprised of stakeholders, policy environment and public policies (p. 46). It is the integrated policy analysis framework advanced by Dunn (1981) which provides the framework for this research study. A detailed description of this framework is provided in Chapter 3. The remainder of this section provides a description of the stakeholders, the policy environment and public policies which have influenced the development of health profession legislation.

Policy Stakeholders

There are three groups which have vested interest in health profession regulation: health professionals as the providers of services, government as the policy-maker and 'payer' of services and the public as the recipient of health services. Each of these stakeholder groups is discussed in relation to their sphere of influence. Since professionalism and licensure are pivotal to any discussion of professional regulation and provide the template on which the issues associated with health profession legislation have evolved, these two components have been 'pulled out' for a more detailed discussion presented in sections three and four, respectively, of this chapter.

The Health Professions

Tuohy and Wolfson (1978) have suggested that the extent to which a group is considered a profession is related to three criteria: (a) the degree of knowledge asymmetry between the patient and the professional, (b) the degree to which the patient delegates decision-making authority to the professional, and (c) the degree to which self-governance, or the authority for the regulation of the practitioners, has been delegated from government to the profession. In the latter case, self-governance is commensurate with a defined practice area in which a profession may have exclusive control over who can provide specific services. Since professional status can usually be translated to mean enhanced social, political, and economic status, groups strive to enhance their position in relation to one or more of the above defining criteria. Furthermore, if there is a perception of "slippage" regarding any one of the criteria, particularly any emphasis on increased government control, or intrusion by others into designated practice areas, a reaction from the profession can be assured (Boase, 1994).

The pursuit of professional status is characterized by several well recognized stages: defining an area of practice, expanding the educational base, defining an exclusive practice area, developing specialities, training assistants, and acquiring social and economic status (Goode, 1960; Wilensky, 1964; Millerson, 1964; Moore, 1970; Freidson, 1970a; Larson, 1977). As these stages evolve, they frequently become the focus of interprofessional conflicts. In particular, efforts to acquire ancillary workers, as part of a professional group, have ultimately led to conflicts as these groups inevitably pursue their own professional journey. The licensed practical nurses are an example of a group that was subordinate to registered nurses prior to obtaining professional status.

For many health care professionals the achievement of self-governance and the exclusivity of practice represent the pinnacle of professionalism. This structure of modern professions emerged in the early part of the century at a time when most professionals were in engaged in private practice and isolated in geographically scattered settings with little reliance on technology (Hogan, 1983; Rose, 1983; Lomas & Barer, 1986). In the unlikely event wherein scopes of practice overlapped between professional groups, resolution was easily achieved by subordination of related workers to a dominant group within a specified field of practice. For example, nurses became subordinate to physicians and dental assistants were subordinated to dentists. In the absence of knowledge on which to judge the competence of practitioners, government delegated to the few existing professions the authority to regulate its members commensurate with the responsibility to protect the public. Thus emerged the rudiments of self-regulation, with the professions, namely medicine and dentistry, acting on behalf of government, on the condition that this authority be exercised in the public interest (Tuohy & Wolfson, 1978).

Self-regulation has endured; however, professional roles and relationships have changed. With the emergence of other health professions, the traditionally dominant role of the medical profession has declined gradually, although physicians continue to be influential in the provision of health services. In explaining this transition, the Ontario Committee on the Healing Arts (1970) stated,

> Since a wide range of health services are now regarded as essential to any modern community, and since many new healing professions have emerged in this century as significant and necessary contributors to health care, it is no longer proper that the medical profession alone should possess the single most decisive influence on patterns and policies of health service. (vol. 3, p. 7)

By the mid-1960s there were at least three other phenomena which contributed to changes in relationships between professional groups and between professions and government: the increasing proportion of salaried workers, the increase in technology and the related proliferation of manpower categories, and increasing government intervention in the delivery of essential public services (Dussault, 1978). Much of the resultant strife was related to the importance which the professions attached to maintaining their self-regulatory status and commensurate economic reward (Boase, 1994). However, many argued that the traditional view of professions as autonomous with monopolistic control over practice areas was incompatible with a changing policy environment (Tuohy, 1992; Pew Health Professions Commission, 1995; Manitoba Law Reform Commission, 1994; Decter, 1997).

The Public as Stakeholders

All discussions which extol the virtues of professional regulation do so on the basis of the 'public interest' despite the fact that those who advocate regulation are, in most cases, the providers rather than the consumers of the service (Wolfson et al., 1980; Lieberman, 1978). The fundamental argument is that given the asymmetry of information, consumers of health care are unable to make reasonable choices with respect to practitioners and services (Benham & Benham, 1978). As Olley (1978) expressed it, "To expect that the user could have even minimal capacity to assess [professional services] . . . is simply unrealistic" (p. 78). The corollary, therefore, is that some form of regulation of health professionals is necessary to protect the public from incompetent practitioners (Trebilcock, 1978; Tuohy & Wolfson, 1978; Castonguay, 1978; Pew Commission, 1995).

The meaning of 'public interest' in any particular context is rarely a matter of general agreement (Schubert, 1960). In a historic study of professionalism in Quebec, Dussault (1978) revealed that the notion of 'protection of the public,' a phrase synonymous with 'public interest,' was "just as imprecise and subjective as the notion of profession" (p. 103). In attempting to advance a sense of meaning to the phrase, Wolfson, Trebilcock and Tuohy (1978) concluded that the terms were generally taken to mean that (a) the policy achieves a just balance among all the relevant interests that should be taken into account, and (b) the policy is consistent with generally accepted principles of efficiency, accountability, fairness, and practicality (p. 182). That is, "members of society want economic entities to minimize waste of society's resources, their governments to be accountable, their systems of justice to be impartial and nonarbitrary, and their administrative systems to be manageable" (p. 183).

Wolfson et al. (1980) pointed out that although reference to public interest was often a prerequisite to an endorsement of a particular viewpoint, it was not a magical formula to rationalize multiple interests. What individual professions brought to any policy debate were those principles they judged to be most appropriate, and which were attentive to the 'individual public interest' (Lomas & Barer, 1986). Indeed, where matters of a scientific, professional, or technical nature were central to the debate, the principle of self-regulation, wherein professions maintained substantial autonomy, best applied (Olley, 1978; Freidson, 1994). However, as Castonguay (1978) noted, "when the general objectives of society [were] being pursued, this principle takes second place" (p. 69).

It is in relation to the broader societal needs in which a number of authors refer to the 'collective public interest' (Lomas and Barer, 1986; Pew Health Professions Commission, 1995). In addition to the public interest in ensuring adequate quality of care provided to each individual, there was a 'collective' public interest in ensuring that resources were used in a technical and resource-efficient manner in the delivery of health services to populations. As Lomas and Barer (1986) pointed out, governments were more likely to possess information concerning the resource consumption by the aggregation of patient-professional encounters and the distribution, roles and incentives of the overall health care system, information which was not available to the professions Thus, it is ultimately the responsibility of government to strike a socially acceptable balance of individual and collective interests once the debate has been heard. It was the latter case which was most likely to be perceived by professional groups as jeopardizing the principle of self-regulation.

Although the protection of the public has been the hallmark of the professions, there has been little in the way of research to determine those factors which are most contributory to the safety of the consumer. Four aspects of professional activity which have been traditionally recognized as important for the protection of the public are: discipline, continuing education, public information, and standards of practice (Dussault, 1978). However, findings from at least two studies suggest that the claim of public protection may exceed the capacity of the mechanisms employed. In a study of twenty-nine health professions in Quebec, eleven had not taken action in any of the four areas and only two had taken initiatives in all four fields. In fact, the characteristic found to be most associated with the protection of the public was the number of years a profession had been in existence (Dussault, 1978). In a later review of five health professions in Canada (dentistry, medicine, nursing, optometry and pharmacy), mechanisms established to protect the public were considered to be in a developmental stage and primarily focused on the identification of poor performers (Fooks, Rachlis & Kushner, 1990). However, any such conclusion has been couched in the knowledge that the number of patients injured or harmed by incompetent practitioners is exceedingly small. Thus, by whatever means, not yet clearly defined, professionals, by and large, provide safe and ethical service. This could suggest that circumstances other than those directly related to activities of the professional associations may be of significance, such as professional characteristics of specialized knowledge, a service interest, and a work ethic.

The Government as Stakeholder

Government-promoted commissions and committee reviews of health care services have been an enduring part of the Canadian health care system. In fact, according to Tuohy (1992), measures to reallocate functions among health personnel and establish alternatives to fee-for-service funding have been on governmental agendas since the introduction of a national health insurance system for medical care in 1966 which effectively "locked in" existing patterns of delivery by underwriting their costs (p. 403). With the passage of the *Medical Care Act* in 1966, provincial governments recognized the need to reconcile the insatiable drive of occupations in their pursuit of professional status, and a burgeoning health workforce responding to an increasingly demanding public, both of which have prompted spiralling health costs and continuous fiscal concerns. Thus began the proliferation of government-initiated commissions, committees and taskforces, an activity which has continued to the present day in every Canadian province.

The earliest of these reviews began in the provinces of Quebec in 1966, hastily followed by several reviews in Ontario, also beginning in 1966, and later by Alberta, in 1972. Although these reviews may, by some standards, be considered 'old,' the spirit of the recommendations, along with their successes and failures, has continued to pervade similar efforts in other provinces over the ensuing decades. Recommendations or findings germane to this present study will be highlighted in the following section. The evolution of health profession legislation in Alberta will be discussed in Chapter 4.

Two of the earliest commissions to review provincial health services were the Quebec Commission of Inquiry on Health and Social Welfare (1970), known as the Castonguay Commission, and the Ontario Committee on the Healing Arts (1970), both culminating in revised professional legislation in 1973 and 1974, respectively. These endeavours were remarkable in their similarity, yet noteworthy in that few of the recommendations were implemented successfully. In providing a rationale for the reviews, both commissions pointed to the changing social context in which professions have evolved: the transition from private practice to salaried positions, expanding fields of practice and the emergence of paraprofessionals, and increased government funding of public services (Castonguay, 1978). Thus, the overriding objectives of each of these commissions were improved access to service, and greater integration of what had been autonomous professional services in order to respond to an anticipated increase in public demand for insured services.

Each of the committees struggled with the need to reconcile the central issues of professional self-regulation, government control, and the public interest, acknowledging that some degree of self-regulation was both desirable and necessary. Both reports were critical of the extent of self-governance which had been accorded the professions, referring to this as an abdication wherein governments had surrendered responsibility to the professions, to the detriment of the public interest. The Commission on the Healing Arts was particularly direct, noting that "society can no longer afford to tolerate a total abdication by government of the right to guide, direct, and, in some areas, become directly involved, in the affairs of the professions" (vol. 3, p. 29). The concern with the failure of the government to supervise delegated authority had been expressed previously in the

McRuer Commission of Inquiry into Civil Rights (1968) in Quebec. Although not primarily concerned with health professional regulation, their recommendations were paraphrased in many subsequent reports. Responding to the proliferation of professions, even apparent in the mid-sixties, the report cautioned that "the power of self-government should not be extended beyond the present limitations, unless it is clearly established that the public interest demands it and that the public interest can not be safeguarded by any other means" (p. 1209).

Policy development in Quebec. The Castonguay Commission, which commenced in Quebec in 1966, was the first provincial review to attempt to place legislated controls on the professions, opting for what it called "moderated self-regulation" (Castonguay, 1978, p. 63). The resultant legislation, the *Professional Code* (1973) was significant in two ways. First, the main function and reason for existence of a profession was formally established as 'protection of the public.' This was the first review to establish this fundamental principle which has appeared in all subsequent legislation reviews in other provinces. Second, the *Code* included provision for the formation of the L'Office des Professions du Quebec, an independent, non-professional body with the authority to regulate new professions and to recommend the continuation, amalgamation, or de-regulation of established professions (Dussault, 1978). This model of 'umbrella' administration over clusters of professions later became evident in Ontario and Alberta. As the first chairman of L'Office, Dussault (1978) acknowledged that the unprecedented authority to "supervise" the professions was based on the publicly stated assumption that "the producers [professionals] cannot, alone and without external supervision, assume the defence of the interest of consumers and of the general public" (p. 101).

Once established, L'Office was compelled to respond to the pressure from professional groups for exclusive practice authority. In reviewing circumstances surrounding these request, L'Office came to the conclusion that exclusive practice mechanisms did provide enhanced public protection by reducing the possibility of incompetent practitioners providing services (Dussault, 1978). However, they also discovered evidence of friction between professions, and concluded that the difficulties were "unresolvable when it came to specifying fields of practice" (p. 108). Since this circumstance had yet to be grappled with in other provinces, the 'resolution' of this issue was conducted under the watchful eye of provincial governments and professions. The policy which was formulated granted reserved title to those professions who practiced in structured environments and were subject to various institutional controls. Authority for exclusive practice areas was granted to those professions wherein professional activities were unobserved by other practitioners (Dussault, 1978). In order to minimize barriers between exclusive jurisdictions, professions were required to authorize practitioners other than their members to execute certain tasks which they would otherwise be restricted from performing. The objective of this mechanism, according to Dussault, was to reduce the rigidity of practice delimitations and "to eliminate one of the major barriers to an improved distribution of professional services" (p. 67).

The three central themes of the Castonguay Commission, i.e., primacy of the public interest, formation of an independent body responsible for professional regulation, and a means of tempering barriers surrounding exclusive practice domains have continued to be evident in subsequent legislative endeavours in other provinces. However, in reflecting on the outcome of the *Professional Code* thirteen years after its inception, Dussault (1986) acknowledged that the overall attempt at regulatory control had "failed" (p. 327). Specifically, the innovative requirement in the Code, that exclusive professions specify duties that could be safely delegated to other personnel, had been effectively sidestepped or simply ignored by the professions. In fact, in his view, the professional associations responded to the legislation by redefining their respective fields of practice in a more precise, detailed and exhaustive fashion, thus further entrenching practice boundaries with no evidence of task delegation to alternate practitioners.

The Quebec experience demonstrated the first, but not the last, of the difficulties associated with a regulatory approach to the rationalization of professional work. As Dussault concluded, "The strength of the major professions often makes regulatory action more harmful than useful. The alternative approach involving the negotiation of collective agreements with professional associations seeking to protect their rights, however, may not be any less difficult" (p. 328).

Policy development in Ontario. Although Ontario cannot be credited with the first legislation review process, it is distinguished for having undertaken the largest of the provincial review processes and perhaps the greatest number of subsequent legislative review processes, having been continuously engaged in some form of review process since the mid-1960s. The Commission on the Healing Arts (1970), comprised of Ian R. Dowie (Chairman), Professor Horace Krever, and Professor M. C. Urquhart, was a four-year endeavour culminating in the *Health Disciplines Act* in 1974. The 1,000-page, three-volume report, completed in 1970, with 354 recommendations, has been widely cited by governments, health disciplines, and academics as being the most substantial and visionary review of professional regulation completed in Canada.

Similar to the Castonguay Report, the Ontario Commission was particularly concerned with the proliferation of health profession groups and the related licensing issues. In an apparent apology for the over-statement of their concerns, they stated,

> We are prepared to risk the impatience of the reader in our emphasis on it. Our investigations have made it clear to us that the primacy of the licensing or regulating body's duty to the public has not always been understood by the body and its practitioners, or, if understood, not always acted upon. It is not true, in our opinion, that what is good for a profession is necessarily good for the country. (Commission on the Healing Arts, vol. 3, p. 44)

It was the proliferation of health professions, and the related legislation, which was perpetuating what this outspoken Commission described as a "wonderland of regulation" reflecting the "confusion, inconsistencies and outright nonsense that has resulted from the separate treatment of the various professions as though they were distinct entities in unrelated industries" (vol. 3, p. 46). In its analysis of what seemed ambiguous, unclear, and questionable regulations, generally passed with little government attention to the coordination of existing and proposed legislation, the Commission advised that "the legislative machinery can only be described as sloppy and, in our view, this sloppiness results from a failure to supervise or recognize any responsibility for supervision of the legislation respecting health professions and occupations" (vol. 3, p. 48). Attention was drawn to the peculiar *Drugless Practitioners Act*, an umbrella act governing a large number of health disciplines such as chiropractors, physiotherapists, massage therapists, occupational therapists, and naturopaths. Introduced in 1925 with subsequent amendments, the Commission cited it as the "final illustration of chaos in the existing legislative regulation of the healing arts . . . and, a designation which surely is confusing and ought never to have been authorized" (vol. 3, p. 47).

In reviewing the overall efficacy of both government and professional actions, the Commission was struck by the extent to which practitioners had been entrusted with powers to exclude unqualified practitioners, to oversee the education of students, and to discipline members, noting the difficulties in defining all practice areas, but particularly the nursing disciplines (vol. 1, p. 89). These circumstances were considered an outcome of the apparent lack of central control, promoting what seemed a troubling amount of bitterness, open conflict, and seemingly intractable jurisdictional disputes between professional groups (vol. 1, p. 90).

The Report of the Commission on the Healing Arts was the precipitant for the *Health Disciplines Act* introduced in 1972. The uniqueness of the Act was in the proposed sixteen colleges for the health disciplines and the inclusion of the twenty-seven groups within this structure, "making possible the provision of consistent procedures and requirements for all disciplines" (Boase, 1994, p. 72). When the Act was finally passed, however, it contained only five colleges: medicine, dentistry, nursing, pharmacy, and optometry (Coburn, 1993). The explanation by the Minister of Health for the retreat from what had appeared to be significant reform indicated that restrictions placed on the powers of the professional associations were a "quantum leap" in progressive legislation and therefore the modifications were an adequate first step in an incremental process (Boase, 1994, p. 72). However, according to Coburn (1993), the revision was the result of strenuous opposition by the professions of medicine and dentistry.

Despite the modification, the new *Health Disciplines Act* retained several structural changes proposed by the Commission. The percentage of lay representatives on governing councils, and complaint and disciplinary committees was increased. A Health Disciplines Board was established similar to that of L'Office du Professions in Quebec. In addition, the Act removed from the colleges the authority to specify minimum admission requirements or a minimum curriculum of studies, transferring the responsibility to the Health Disciplines Board (Ontario Commission on the Healing Arts, 1970). Not surprisingly, the legislation was not met by a rush of professional support, particularly from the influential Colleges. Boase (1994) described it as a time of "ferocious interest group activity" which may have motivated the Minister responsible to commission yet another professional regulation review.

By the end of the 1970s, it was clear to policy-makers and professionals that the *Health Disciplines Act* had not resolved the confusion, dissatisfaction, and acrimony among health care workers and immobilization at the policy level (Boase, 1994, p. 128). Members of the public were expressing doubts about professional investigations of patient complaints, a number of unregulated health care groups were pressing for recognition, health professions regulated by outdated statutes were seeking regulation under the Health Disciplines Act, and hospital administrators were expressing frustration with the rigidity of the existing regulatory system imposed on their deployment of health workers. The five 'major' disciplines perceived the existing Act to be inflexible, interest group input was intense and adversarial, and the existing patchwork of legislation disallowed a coordinated policy direction (Health Professions Legislative Review, 1989, p. 5). In short, there was very little perceived as 'right' by stakeholders.

Thus, the Health Professions Legislation Review (HPLR) was commissioned in 1982, directed by A. Schwartz, a lawyer and former consultant on government policy, with a broad mandate to produce draft legislation that was in the 'public interest' (p. 6). The extensive consultative process included a review of 200 groups and 75 health occupations and occurred over the course of three changes in government and the appointment of a total of six Ministers of Health (Health Professions Review Committee, 1989, p. 5). Each change prompted another round of ministerial briefings as each professional association expressed anew their concerns that the proposed legislation would threaten their autonomy and erode their self-regulatory authority (p. 5). In 1991 the decade-long process culminated in the passage of the omnibus *Regulated Health Professions Act* along with profession-specific Acts (Bohnen, 1994). The Act represented a radical departure from traditional professional legislation, and became a template for other provinces, including Alberta. What distinguished the review process from its predecessors was the apparent 'no-nonsense,' judicial-like approach by the review committee and their relentless efforts to verify vague charges against another profession or predictions of potential harm to the public (Boase, 1994).

A unique feature of the *Regulated Health Professions Act* was the distinction between exclusive scopes of practice and 'controlled' acts. Exclusive practice jurisdictions were eliminated and replaced by list of 13 'controlled' acts which include: communicating a diagnosis, performing procedures below the skin, setting fractures, manipulating the spine, administering injections, prescribing drugs, and others. Only regulated health professions were authorized to perform these acts in accordance with the terms and conditions in regulations. All non-restricted acts could then be performed by any professional or non-professional. This significant departure from previous forms of legislation was based on the assumption that only a small number of acts or procedures, performed by professionals, placed a patient at serious risk. Therefore, to authorize exclusive practice areas was to restrict, unnecessarily, the performance of relatively safe practices by competent practitioners (Health Professions Legislation Review, 1989). Since every profession had their own Act as part of the omnibus Regulated Health Professions Act, this policy direction was arguably an attempt to ameliorate professional rivalries centered on broadly defined exclusive practice jurisdictions (Bohnen, 1994). It also permitted areas of overlap, narrowing the range of exclusivity from what had, in some cases, been a broad field of practice to what were specific prohibited activities.

After nine years of legislative debate, the views of professions reflected the full gamut of responses. As Boase (1994) concluded, "If the object of public policy making in a highly controversial area is to fully satisfy no one and totally alienate no one, then, in this sense, the review was reasonably successful" (p. 158). Seven years after the passage of the Act, the development of regulations for each of the 25 professions continues. How the government will feel in the future when called upon to administer the results of Schwartz's (1982) work remains to be seen.

In concluding the discussion of the commissioned reviews in both Quebec and Ontario, I find it evident that the complexity of the health care system had created an enormous challenge to governments to try and disentangle professional arguments legitimately based on the public interest from those motivated by self-interest. As Boase (1994) noted, "Governments are compelled to make decisions which are . . . politically expedient, scientifically sound, and economically wise" (p. 15). In reality, the attendant contradictions have been so acute they have engendered "innumerable studies, ambivalence, indecision, equivocation, even paralysis" (p. 91).

Policy Environment

As Dunn's model would suggest, the circumstances surrounding health profession legislation is best understood within the context of national intervening events and ideologies. Provincial legislation determines the manner in which professionals provide and are remunerated for health services to the public. However, although health services are a provincial matter, the dependence on transfer payments from the federal government ensures that federal-provincial relations significantly influence health policy formulations and the regulation of health professionals. Since health care is a publicly financed service and professionals and paraprofessionals absorb a substantial proportion of health care funding, controversies over the regulation of the health disciplines are qualitatively different from those of other professions. With the introduction of cost-sharing federal-provincial responsibilities in the 1960s, health economics, intergovernmental relations, and the regulation of the health disciplines have been inextricably linked (Starr & Immergut, 1987; Boase, 1994).

Historically, the provision of health services and the regulation of health professionals have been monopolized by the medical profession, a circumstance which is now being challenged by many other well-educated groups; e.g., nurses, chiropractors, optometrists, pharmacists, and physical therapists (Blishen, 1991; Boase, 1994; Benoit, 1995). An industrialized society is a professionalizing society, according to Goode (1960). Thus, as predicted, technological change has resulted in a proliferation of these highly educated groups, each with a legitimate claim to professional stature, inclusive of a body of specialized knowledge, an exclusive practice domain, and a desire to enhance their economic opportunity through inclusion in the health care network as a provider of insured services. This pursuit of professional status has become fundamentally incompatible with the efforts of the medical establishment to protect its threatened position from incursions by a number of professional groups. In attempting to redefine the position of physicians, these groups have rejected the traditionally hierarchical, superior/subordinate relationships within the health field (Coburn, 1993).

Physicians have been tenacious in their efforts to resist advances made by non-physician groups into arenas hitherto the exclusive domain of medicine. In protecting their own position as gatekeepers of the health system, this approach by the medical profession has become increasingly outdated (Blishen, 1991; Freidson, 1994; Abelson, 1997). Advances within health sciences has precluded their claim to comprehensive knowledge of all forms of traditional medical practice. This circumstance has been exacerbated, if not aggravated, by the technological complexity of the health care field, requiring government to depend on a variety of professional groups, in addition to medicine, to aid in the formation and implementation of health policy (Boase, 1994). Yet, in adding a pluralistic dimension to the health policy process, these complicated relationships have become both cooperative and competitive (Tuohy, 1992). According to Boase (1994), the central issue has become the increasing conflict between professional groups within a shifting environment, provoking provincial governments to re-examine regulatory legislation in an attempt to unravel professional arguments and bring rational planning to a complex and historically resistant problem (p. xx).

Public Policy

In retrospect, the catalyst that led to the shifting policy environment for health professions was the *Medicare Act* first introduced in Saskatchewan in 1962 and federally in 1966 (Taylor, 1987). Although the introduction of a national and comprehensive insured health service profoundly altered the course of health service delivery, it was positioned centrally amongst other factors affecting the context and evolution of health care policy in Canada.

Health Policy Prior to 1945

Prior to 1945, private enterprise predominated in a health care system led by physicians who were free to define a broad scope of practice and establish a fee schedule. As the 'hand-maidens' of physicians, nurses vacillated between a dependent and independent role, receiving remuneration largely on the basis of a patient's ability to pay (Cashman, 1966). During this period, government policy was primarily dictated by the medical profession, who established not only their own regulatory legislation, but also controlled the legislation of the nursing profession.

Health Policy From 1945 to 1970

From 1945 to the mid-seventies, health services were transposed from the private to the public realm with Canada's adoption of comprehensive government-sponsored insurance for hospital services in 1957 and for medical services in 1966 (Tuohy, 1986). With the introduction of these insured services, comprehensive coverage of health care quickly came to be viewed by Canadians not only as a social right but as a politically popular program which no government in the future would seriously consider dismantling (Taylor, 1978; Manga, 1993). However, for health professionals, particularly physicians, this was a turbulent period, and one marked by a bitter strike by physicians in Saskatchewan following the introduction of the first tax-supported, publicly administered medical care insurance plan in North America in 1962 (Boase, 1994, p. 15). In essence, physicians had moved from autonomous private practice to becoming, in a sense, employees of the government. And, health professionals, in general, became more involved in the administrative constraints of health services, a circumstance which increasingly became the antithesis of professional autonomy (Taylor, 1978; 1987).

Nevertheless, the political control of health care remained limited by the power and authority of the medical profession, a position reinforced by the reticence of governments to confront a well-organized pressure group (Starr & Immergut, 1987).

By the early 1970s, shortly after the introduction of Medicare, both federal and provincial governments were viewing with alarm the escalation in health care costs. At least three factors were identified as contributory: (a) the relatively open-ended funding mechanisms generated by federal-provincial cost-sharing policy agreements, (b) the increasing demand by consumers for expansion of medical services and the resultant growth in health care facilities, and (c) the dramatic increase in the number of health professionals and the accompanying demand by professional associations for inclusion as an insured service (Weller, 1980). Van Loon (1978) and others have argued that once health care was financed through a public authority, public finance considerations have remained a dominant theme. As Manga (1993) noted, "Cost containment has become the touchstone of virtually all health care policy decisions, . . . dominating the health care reform agenda of all provinces" (p. 177). Faced with concerns regarding the financing of the health system, governments engaged in federal-provincial cost-sharing disputes, with secondary attention given to substantive health issues and restructuring of the system, although the Canadian Nurses Association and other groups were attempting to promote such discussion (Boase, 1994, p. 42).

With financial concerns predominating, governments came to the realization that self-regulating professions seemed in conflict with the goals of publicly funded services. What had been a health system predicated on a private and personal patient-practitioner relationship had evolved into a political and public discourse. The prerogative of professions to define issues as technical and scientific, and therefore outside the purview of political decision-making, was challenged by governments, awakened to a pressing need for political and bureaucratic leadership (Starr & Immergut, 1987; Blishen, 1991; Manga, 1993). As Manga and Weller (1983) stated,

> The cause of greater economic efficiency could be better served by having the state take back increasing amounts of the power it earlier delegated to the dominant professionals, and to use that power to effect a shift toward less expensive forms of delivery, and away from profession-dominated, technology-oriented, high-cost medicine . . . and to impose a number of regulatory and control devices. (p. 515)

During this period a pluralist framework of policy analysis depicted the prevailing policy environment wherein the presumption was that public policy was the result of competition among groups pursuing their own interests (Pross, 1975). Some suggested that this paradigm was akin to elitist theory (Dye, 1992), others refer to the influence of policy communities (Rhodes, 1986), policy networks (Pross, 1992), or Gilbs' (1966) earlier depiction of 'private governments.' As relatively synonymous terms, these concepts all referred to groups who, by virtue of their functional responsibilities, restricted membership, vested interests, and specialized knowledge, had acquired a dominant voice in determining public policy.

Under this pluralistic framework, governments were generally characterized as reactive in response to pressure group influence (Atkinson & Coleman, 1989; Manga, 1993; Boase, 1994). Regulatory decisions were generally decentralized to the self-regulating professions and were characterized by a competitiveness amongst non-medical professions to achieve legislation similar to that of physicians. Legislative achievements in areas such as direct access, private practice status, duration of university education programs, licensing requirements, exclusive scopes of practice, and restricted titles were all sought after by professions, often on a win-lose basis, and always requiring the sanction of the medical profession. Thus, the pressure group or bottom-up theory of policy making was prone to "dysfunctional consequences" with policies providing short term solutions reflective of dominant interests, and which contradicted previous decisions (Atkinson & Coleman, 1989, p. 60). The resultant policies were therefore characterized as non-comprehensive, changing only incrementally from those already in existence (Weissert & Weissert, 1996). However, as Hayes (1992) suggested, a nonincremental policy approach was "simply impossible" given the diversity of professional interests (p. 36).

Health Policy Since 1970

Beginning in the 1970s, the stage of 'government regulation' evolved, founded on the belief that health resources should be publicly allocated and accountable and that governments ought to be more proactive in establishing long term policy directions (Lomas & Barer, 1986; Contandriopoulos et al., 1986). Thus, after a long period of 'hands-off policy,' federal and provincial governments began to pass a series of new regulatory and reform measures to improve access to services and control health care cost (Starr & Immergut, 1987; Decter, 1997). Of significance during this time was the successful lobby effort of the Canadian Nurses' Association to amend the *Canada Health Act* (1984), permitting health care practitioners (as distinct from the medical practitioners) to provide insured services external to an institutional setting (Boase, 1994, p. 48). Ironically, this was also a period in which an escalating number of professions were successful in their lobby efforts to be recognized as a regulated service as a prerequisite to inclusion as an insured service provider. Since wages, salaries, and fees comprise approximately 75% of health care expenditure, the increases in regulated practitioners paralleled rising health costs (Manga, 1993). As Boase (1994) concluded, governments would be compelled to re-examine their health care systems, specifically the regulatory legislation governing the health professions (p. xx). In her view,

> governments, faced with the need to make decisions in a technologically complex, publicly funded and increasingly expensive field, where there are high expectations of practitioners for career satisfaction and of the public

> for accessible and competent care, will be [compelled] to move towards proactive rather than reactive decision making. (p. 175)

In more recent times, there has been a shift away from a medically-dominated, competitive, pluralistic ideology to a corporatist model of policy development (Boase, 1994; Tuohy, 1976). Acknowledged as an elusive term, it is a model which encourages cooperation and consensus, and particularly the involvement of interest groups in policy formulation and implementation. In its application to changes in the health care environment, this shift constituted a more balanced relationship between the health care sector and government. Cawson (1985) best described it as one in which "organizations representing monopolistic functional interests engage in political exchange with governments over policy outputs which involves those organization in a role which combines interest representation and policy implementation through delegated self-enforcement" (p. 38). In furthering this description, he depicted an interventionist government role as a requisite to what has become a trend toward the "fusion of representation and intervention in the relationship between groups and government" (p. 39). Despite this trend, professions have continued to successfully guard their considerable autonomy to control not only the content of their practice, but also the context within which they practice (Lomas & Barer, 1986). Conflict, therefore, is inevitable in relation to policy-making processes. An examination of the nature of professionalism leads to a better understanding of the conflictual dynamics of health profession legislation. The following section, therefore, focuses on the transition of occupations to professions and the ideologies which emerge.

THE ROOTS OF PROFESSIONALISM

> [Professions] inherit, preserve, and pass on a tradition. . . . They engender modes of life, habits of thought and standards of judgement which render them centres of resistance to crude forces which threaten steady and peaceful evolution. . . . The family, the church and the universities, certain

> associations of intellectuals, and above all the great professions, stand like rocks against which the waves raised by these forces beat in vain. (Carr-Saunders, 1933, p. 497)

Many of the issues which have evolved in relation to health profession legislation have been rooted in the fundamental ideologies and interests of professionals. The familiar matrix of tasks involving specialized knowledge, high levels of formal training and regulation and licensing by professional associations have shaped the standards and patterns of provision of health services and the legislative authority to do so in a manner largely outside the scrutiny of external observers. The following section is a discussion of the conceptualization of professions as a background to understanding the principles of work organization in the health field, and the means by which professionals have sustained fields of practice.

The Trait-Functionalist Era

The attempt to define a profession has captured the attention, if not the obsession of sociologists for decades. Until the early 1970s the literature was replete with efforts to define the term 'professional' and delineate the differences between professions and other occupations. Following the initial efforts by Flexner (1970, p. 155) to define the essential elements constituting a profession, the discourse over definitions, lists, criteria, characteristics, and functions of professions generated little in the way of a scholarly synthesis (Carr-Saunders, 1933; Cogin, 1953; Parsons, 1954; Millerson, 1964; Durkheim, 1966; Greenwood, 1966; Goode, 1969; Moore, 1970; Freidson, 1971). Models of this 'functionalist-trait' era consumed the literature, imbedded in statements which Haug (1975, p. 198) described as "drearily familiar" and Johnson (1972) claimed generated "confusion so profound that there is even disagreement about the existence of the confusion" (p. 22). Typical of the confusion, were the acclaimed writings of Goode (1960) who pronounced that "if one extracts from the most commonly cited definitions all the items which characterize a profession . . . a commendable unanimity is disclosed. There are no contradictions and the only differences are those of omission" (p. 903). In contrast, and also of considerable scholarly stature, Millerson (1964) disagreed, asserting that "of the dozens of writers on this subject, few seem able to agree on the real determinants of professional status" (p. 15). In the midst of the rhetoric, another group of scholars (Hughes, 1958; Haberstein, 1963; Elliot, 1972; Halmos, 1973) advised that the seemingly endless argument over the defining configuration of a profession was best abandoned, since the concept was indistinguishable from most other occupations and merely a symbolic label for a desired status. Thus, in recapping this era, Freidson (1994), considered to be the prolific 'dean' of professionalism, declared that "scholarship concerned with the professions was in an intellectual shambles" (p. 5).

Nevertheless, despite a lack of consensus about which traits constituted the essential elements of a profession, theorists of this early era relied on the core characteristics of specialized knowledge, work autonomy, and a service ethic, as central to what seemed to constitute a profession (Stinson, 1969). Of these characteristics, the specialized body of knowledge seemed primary, and the basis from which other attributes emerged.

Specialized Knowledge

Wilensky (1964) observed that in the minds of lay public and professional groups, the criteria of distinction seemed embedded in the notion that the job of the professional was based on knowledge acquired through a formal and lengthy prescribed training process in an exclusive occupational jurisdiction (p. 138). This technical knowledge was not necessarily scientific, according to Wilensky, but distinguished by rigorously defined and enforced standards of training designed to impart the distinctive features of each profession's functions and background. The success of the claim to a 'technical' base was the greatest where society evidenced strong, widespread consensus regarding the knowledge or doctrine to be applied (p. 138). The authority over this sphere of technical expertise was the base from which professional occupations controlled their practice and gained leverage in relation to social power (Brint, 1994). As Freidson (1971) noted, “Knowledge itself does not give special power: only *exclusive* knowledge gives power to its possessors” (p. 28). However, expert knowledge was, of itself, not influential. The influence of professional knowledge depended on what Larson (1977) termed the “monopoly of credibility” with the public (p. 17). As Krause (1977) described it, “The power of expertise lies in the fact that it is a necessity” (p. 237).

Much of the specialized professional knowledge was intentionally shrouded in mystique as a tactical device to establish prestige and power. According to Freidson (1986), this formal knowledge remained separate from common, everyday knowledge, rooted in “languages known only to a few, and expressed in terms unfamiliar to many” (p. 2). This “mystery,” said Goode (1966), was beyond the capacity of the ordinary man (p. 34). In order to acquire and retain the confidence of his patient, and believing that the patient was incapable of appreciation for the art of medicine, the physician conveyed a “pompous assumption of knowledge and authority,” wrote Carr-Saunders and Wilson (1966), “surrounding himself with an atmosphere of mystery and miracle” (p. 104). Not exclusive to physicians, “the art and rituals of the court, performed with brilliance and finesse, might be less a procedural necessity than a need to dazzle the client,” claimed Hughes (1951, p. 324). However, it was Caplow (1954) who first warned that the mutual incomprehensibility of “occupational languages” and the proliferation of rigidly organized occupational specialty groups would produce the unintended consequence of barriers to communication in the general society (p. 29).

Professional Autonomy

The idea of specialized knowledge generating autonomy was reflected in Wilensky’s (1964) contention that a profession represented a “monopoly of beliefs justifying a monopoly of activity linked to exclusive possession of competence in a specified area" (p. 141). However, the extent to which professionals made independent decisions was not necessarily an index of autonomy, claimed Hughes (1963). It was "the *right* to make judgments that was most sought after and jealously guarded" (p. 650). The main instrument of professional authority was the capacity to claim esoteric knowledge and identifiable skills, or to create and control a cognitive and technical base. The claim of expertise was directed towards gaining social recognition and prestige, enabling professionals to assert authority and engender respect (Kimbel, 1992). Thus, wrote Hughes (1963), "Each profession considers itself the proper body to set the terms in which some aspect of society, or life, is to be thought of" (p. 651). Licensing of members, or the "charter of autonomy" given by a legislative act, ascribed authority to define the terms of practice and "a legal, moral, and intellectual mandate to determine for the individual and society what is healthy, moral, ethical, normal, or abnormal" (Reiff, 1974, p. 452). It was this claim to exclusive knowledge that became a strategic factor in the pursuit of self-governance and the ultimate goal of autonomous practice (Larson, 1977). Justification for this pursuit was always predicated on the professional assumption that the public was not sufficiently informed to adjudicate professional practice, nor could those of related disciplines be trusted to engage in such judgement (Gouldner, 1979).

It was the professional association which provided the structure and legitimating influence for the autonomy of its members. The early rudiments of professional associations became the embodiment of formal organization among the professions and the means by which the collective interests of its members could be expressed politically. Shortly after their inception, they sought freedom for their members from undue government influences, encroachment of other occupational groups, and interference of the public (Goode, 1960). Millerson (1964) argued that what ultimately distinguished professional associations from other types of occupational organization was the scope and depth of authority over technical skills and ethical standards. It was the high degree of specialized knowledge which provided the source of cohesion in professional occupational groups, and the legitimating basis for autonomy as the professional association "attempts to gain individual and collective freedom from those who might otherwise dictate to him" (Gilb, 1966, p. 54). Justification for the claim to exclusive possession of knowledge and the associated autonomous practice was further embellished by an image of altruistic service provision.

Altruistic Service

A service orientation, according to Goode (1966), meant "that the professional decision is not properly to be based on the self-interest of the professional, but on the need of the client" (p. 36). In contrasting business and the professions, Parsons (1954) noted that there were elements common to both. Indeed, professions were to be distinguished from the business community by a membership which was restricted to those with a high degree of honour and motivated by the pure ideal of rendering service. Professional practice hinged on a system of standards embodied in a code of ethics requiring exemplary behavior by the members of the profession. The source of this legitimating ideology was rooted in the traditions of upper-class altruism and religious leadership, commanding the professional obligations of being honorable, generous, and responsible (Collins, 1979). The image portrayed was of selfless dedication to the community good and service-orientated attitudes—to do no harm, to act in the client's interest, and to preserve the client's trust and confidence (Gross, 1977).

A Shift in Focus From Professions to Professionalism

By the 1960s scholars were struggling to decipher the contradictory mass of writings that had accumulated over the previous decades. Dissatisfaction with attempts to discern the defining characteristics of a profession on the basis of trait theory stemmed from the realization that many of the attributes were contrived arbitrarily to justify desired outcomes. In addition, since many occupations satisfied at least some of the attributes, such as formal training programs, professional associations, and licensing requirements, the trait-functionalist approach blurred the distinctive meaning of the term (Johnson, 1972).

The 1960s were characterized by what Freidson (1994) called a "watershed of scholarly writings on professionalization" (p. 13). Attention shifted from a substantive preoccupation with definition to the process by which occupations were professionalized (Vollmer & Mills, 1966). This shift in ideology was aptly described in an often quoted statement by Hughes (in Vollmer & Mills, 1966):

> In my own studies, I passed from the false question, "Is this occupation a profession?" to the more fundamental one, "What are the circumstances in which people in an occupation attempt to turn it into a profession, and themselves into professional people?" (p. v.)

Over the next decade, a series of scholars became identified with a brief, circumscribed period in the historical development of professions. In fact, Carr-Saunders first referred to the notion of "professional progressiveness" in what was considered a classic work published in 1933 (p. 496). However, Caplow (1954) was one of the first writers who maintained there were sequential stages involved in the process of professionalization: (a) the establishment of a professional association, with definite membership criteria designed to keep out the unqualified, (b) a change of name to reduce identification with the previous occupational status, (c) development of a code of ethics, and (d) political agitation to obtain the support of the public in maintenance of occupational barriers.

Goode (1960) was another of the prominent scholars of the era seemingly best known for his often quoted claim that "an industrializing society was a professionalizing society" (p. 902). He also suggested that there was a natural history to the professions, promulgated by an elitist membership and which included: formulation of a code of ethics, founding of a professional association, publicizing the unique contribution of the occupation, lobbying for favourable legislation, and development of a university-based training program.

The stages of professionalism, as described by Caplow and Goode, were not dissimilar from those of Millerson (1964), Wilensky (1964), Moore (1970), and Harries-Jenkins (1970). Of these, Wilensky has been the most enduring. In an often-cited article, "The Professionalization of Everyone?" he pointed to the phenomenon of professionalization as increasingly affecting every occupation. However, while there was a tendency for occupations to seek professional status, he predicted few would succeed since many occupations asserted claims to professional status not recognized beyond the group. In an attempt to answer the question, "Is there an invariant progression of events, or path, along which they [professionals] travel to the promised professional land?" (p. 142), Wilensky identified stages which became a classic model for the pursuit of professional development (p. 142). Initially, workers engaged themselves in an occupation on a full time basis, staking out a jurisdiction. Participants then became concerned about standards of training, establishing a training school, which, if not located in a university at the outset, ultimately occurred. Through such connections, educators and activists achieved success in promoting a more effective organization, first local, then national, through either the transformation of an existing occupational association or the creation of a new one. Legal protection of the monopoly of skill was promulgated by the association, licensure or certification requirements were defined and a formal code of ethics was adopted. If, according to Wilensky's model, professions went through this process and adhered to professional norms, extraordinary autonomy, or the authority and freedom to regulate themselves and act within their spheres of competence was the eventual reward (pp. 144-146). Whether or not the model was appropriate for all evolving occupations, it was a stereotype familiar to the lay public and professional groups and, as such, provided a framework to understand the historical development of occupational groups aspiring to become professions, or as a means to analyse their failures.

Wilensky's (1966) work was significant. In essence, it drew the line between the older functionalist and idealizing view of professions and what some came to be viewed as the 'revisionist' theories of professionalization. His model was itself a theory about differences among occupations, based on specific conditions which collectively charted the path to professional autonomy. Although it looked backwards in laying out a sequence through which professions pass, it looked forward in the sense of providing a model of occupational development based on power. Those who followed emphasized the dynamics by which professional status developed, privileges obtained in the achievement of professional stature, and the political, cultural and economic influence of occupational elites.

Although the focus on professionalization in the 1960s brought to an end decades of confusing if not contradictory preoccupation with the emerging ideology of professions, there was a remarkable unanimity that professions represented a distinct kind of occupation which were growing in number and importance (Trebilcock, 1978), were of importance to the effective and humane functioning of modern society (Freidson, 1994), and which would continue to exert increasing importance in the future (Bell, 1976).

Conceptualizations of Professions

By the early 1970s, theorists were directing their attention to conceptual views of professionalism (MacDonald, 1995). The legitimacy of professional authority was challenged as deflecting attention away from the more fundamental pursuit of power and prestige. This normative shift in the general assessment of professions was likewise accompanied with a theoretical shift as scholars began to emphasize contextual and structural factors in analyzing how professionals gained authority over a domain of practice. Whereas the trait-functionalist approach explained professions in terms of the validity and utility of expertise, the more contemporary structuralist approach emphasized the socio-economic structures that sustained professional associations. Attention shifted to such ideologies as professional power, control and dominance, themes which in one form or another have dominated the literature to the present day and formed the basis for emerging criticisms. In fact, the 'power approach' included a range of emphases, becoming a label to refer to all those who had abandoned the earlier orthodoxy (Kimbel, 1992).

Organized Autonomy

Freidson (1970) himself made little use of the word 'power,' preferring the term 'organized autonomy,' reflecting its license and mandate to control its work, granted by society by virtue of winning the support of a political, economic or social elite (p. 71). However, his six textbooks and numerous articles gave a strong impetus to a new kind of study of the professions with a focus on power and conflict (1970a; 1970b; 1971; 1980; 1986; 1994). Although his work was based on health professions and primarily the practice of medicine, he believed his work was a model for the analysis of professions in general. The themes of his work reflected an analysis of the ideology of professional claims, unjustified aspects of monopolistic privilege, how the medical profession attained its autonomy and extended its dominance over clients and neighbouring occupations, and the formal control of members with ostracism of the non-compliant.

Perhaps his greatest contribution was to clarify the nature and process of professional privilege. His examination of the "archetypal" profession led him to conclude that, unlike other occupations, professions were "*deliberately* granted autonomy, including the exclusive right to determine who can legitimately do its work and how the work should be done" (1970b, p. 72). Autonomy was, however, only "technical, not absolute" (Freidson, 1970, p. 72). While a profession was subordinated to the state in relation to the social and economic organization of work, control over the technical aspect of their work or the sphere of specialized knowledge, remained with the profession. Thus, as long as a profession was free of the technical evaluation and control of other occupations, the lack of control over the socio-economic terms of work did not significantly change its essential character as a profession (Freidson, 1970, p. 25). However, Freidson warned that autonomy could foster insularity. "Professionals live within ideologies of their own creation, which they present to the outside as the most valid definitions of specific spheres of social reality" (p. 73).

The Professional Project

More recently, writers have referred to the progressive attainment of professional monopoly as the 'professional project' (Larson, 1977; Burrage & Torstendahl, 1990) or the professional imperative (MacDonald, 1995). This approach was concerned with the ways in which professionals constructed a specialized knowledge domain and established a monopoly of services derived from it. Inherent to the project were recognizable stages of development common to most professional groups: demarcation and protection of jurisdictions within which professionals were entitled to practice; control of training programs and entry to practice standards; and the protection and enhancement of professional status (Burrage & Torstendahl, 1990). Although there was seldom overt reference to the pursuit of practice monopolies as a professional goal, the intent was apparent.

Larson's (1972) conceptualization of professions built on the work of Freidson. She depicted professions as interest groups, linked to the class system of capitalist societies and professionalization as a "collective mobility project" in which occupations seek to improve their economic position and social standing (p. xvi). The central theme of

Larson's work was how professions organized themselves to attain market power. She conceptualized professionalization as the process by which producers of special services sought to constitute and control a market for their expertise. Professionalization was a means of earning an income on the basis of transacted services, in a society that was being reorganized around the centrality of the market (p. xvii).

Professions as Jurisdictions

Abbott (1988) conceptualized professionalism as a system of competitive occupational relations centering on jurisdictional claims and disputes. As if a reflection of Turner and Hodge's (1970) early prediction that it would be unlikely that any group could enforce a monopoly over all services to which it lay claim, Abbott described the struggles between occupations for jurisdiction over realms of expertise as the "determining history of the professions" (p. 2). According to Abbott, experts were continuously engaged in making claims and counter claims for jurisdiction over existing, emergent and vacant areas of expertise. In claiming jurisdiction, a professional group sought recognition for the right to a monopoly of practice, self-discipline, unconstrained employment, and control of professional training, recruitment, and licensing. However, since the professions were a part of the social system of work, he predicted that a "fundamental fact of professional life included continual thwarting of jurisdictional disputes" (p. 2). However, if a profession was successful in convincing public policy-makers of the need for the legislated right to an exclusive jurisdiction, professional autonomy was assured.

Attributes, Ideologies, and Health Policy

The description of attributes and ideologies which have been central to the emergence of professions and professionals is more than a preoccupation of academic interest. It has significant implications for health policy. The model of professionalism which emerged around the turn of the century remains the image of professionalism to the present day: a body of specialized knowledge acquired through a university education, dedication to the interests of patients, development of provincial associations and lobbying government ministers (Manitoba Law Reform Commission, 1994).

Professions continue to argue convincingly that only individuals who have completed the requisite years of university and are engaged in practice are capable of setting and enforcing appropriate standards for practitioners. They have contended, with success, that non-professionals are not able to identify improper conduct on the part of professionals and so cannot be trusted to control the activities of practitioners. Therefore, they have taken the position that, while government is able to administer regulatory regimes for other occupations, its only option in relation to professions is to delegate to professionals the power to administer their own affairs (Rose, 1983; Trebilcock, 1983; Tuohy, 1986; Gross, 1988). Moreover, they have argued that because professionals are individually and collectively devoted to the best interests of the public the delegated authority to set and enforce their own standards is justifiable. Accordingly, professional bodies have typically been granted the authority by legislatures in Canada to set and enforce standards for initial membership in the professional body and for standards of professional conduct after entry (Manitoba Law Reform Commission, 1994; Sutherland, 1996).

The power of self-government, particularly in the achievement of licensing regimes, gives practitioners a great deal of authority to define the services which members have the exclusive right to perform (Lieberman, 1978; Tuohy & Wolfson, 1978). Legislation is often vaguely worded, thus allowing professions to expand its scope of practice with minimal legal opposition. By controlling the number of new practitioners, a profession can control the competition faced by its members by establishing fee schedules and restricting advertising. In addition to power and financial benefits, obtaining professional legislation also represents status and respect, and is usually the culmination of what has been the primary objective of a group to raise the standards of service of the occupation and acquire the related recognition (Benham, 1972; Ostry, 1978; White, 1983; Gross, 1988)

For most professions, regulatory legislation has been obtained without serious difficulty. The occupation is usually well organized and well financed, commanding the attention of legislators (Young, 1988; Gross, 1987). In the absence of significant opposition by another professional group whose interests are threatened by the regulation being sought, there is little reason for government not to support the legislation. Groups who oppose legislation of other groups always claim that their opposition is in the interests of the public which the legislation is intended to protect. The result is a political struggle which is usually resolved either by negotiation between the competing groups, or by a legislative choice as to which approaches to support (Brint, 1994).

This traditional approach to occupational regulation has resulted in the proliferation of professions, largely because of the increasingly specialized programs in universities, the advantages of professional status to graduands and little public or bureaucratic opposition to the process (Rubin, 1980). At the same time, however, doubts surfaced about the wisdom of granting self-governance authority particularly in relation to an emerging body of literature which challenged the basic rudiments of professionalism (Manitoba Law Reform Commission, 1994).

Professions Under the Microscope

No particular turning point marked the passing of what some felt was a naive view of professionals and professionalism (Friedman, 1962; Young, 1988). For more than fifty years, many, including professionals, assumed that professionalism, although manifesting some abuses, served the public interest. Nevertheless, the transition from unchallenged acceptance of professions to scepticism about its social benefits can be traced through a series of initially innocuous events to more public debate.

By the 1950s, a few scholars were distancing themselves from their benevolent colleagues. They were introducing the possibility of unflattering interpretations of professions, suggesting that professionalism was a device by which the self-interest of a work group could be furthered (Cogan, 1953; Friedman, 1962). The first evidence of criticism towards the professions appeared in 1945 when Friedman and Kuznets published a study on the effects of professionalism and income levels. Although their research was the first to provide empirical evidence challenging professional licensure laws, the findings were largely ignored by the social scientist community. It wasn't until Gellhorn (1956) and Friedman (1962) later addressed the issues of licensure that scholars began to view government regulation as a malevolent force restricting competition and raising costs to consumers. In 1958 the *Journal of Law and Economics* appeared as the first publication to contain articles on the effects of regulation. Beginning with articles by Kessel (1958) on the cost of medical regulation, and Moore (1961) on the covert purposes of licensure, publications, particularly on the economics of professional regulation, flourished. Stigler's (1971) economic model of regulatory behavior, which contravened the traditional public-interest view, furthered the curiosity and scepticism about the assumptions of professional regulatory practices.

Yet, despite pockets of criticism, the number of health professional groups proliferated at unprecedented rates, seemingly impervious to outside forces. The public had a need for, if not dependency on, the knowledge and skills of professionals, sustained by the inability to evaluate the technical merits of services provided and justifying the prohibition of practice by anyone who has not undergone the scrutiny and approval of licensure (Rubin, 1980). The political successes at the legislative level resulting from the dynamics of small, well-organized, and special interest lobbying have become a critical ingredient supporting continued professional control of the professions (Tuohy, 1992). And legislative committees, in the absence of concerted opposition, have continued to rely on professional assertions that regulatory controls were necessary to protect the public (Young, 1988).

Since the 1970s, two forces seem to have co-existed, each aware of, but relatively unaffected by the other. Professional groups have continued to pursue, and succeed in attaining, broadened, and in some cases, exclusive scopes of practice. Various attempts by government to revise regulations have had virtually no effect on the allocation of functions among health care personnel (Castonguay Commission, 1970; Ontario Commission on the Healing Arts, 1970; Tuohy, 1994; Sutherland 1997). External to the professions, economists and sociologists continue to generate a dramatically different body of literature challenging the cornerstones of professionalism, remarkable in the relative absence of published support for the public interest theory of self-regulation.

The earliest and primary target of such criticism was medicine—how it dominated social policy, other related occupations, and patients; and how it had medicalized personal and social problems (McKinlay, 1973; Berlant, 1975; Illich et al., 1978). As other health professions came to be viewed under a similar lens, the literature turned to a variety of themes: the decline, or at least the loss of status of professions in general; the decline of autonomous practice (Blishen, 1991; Coburn, 1993; Brint 1994); the impact on professions of financial and administrative policies undertaken by public and private institutions, including governments; changes in the health labour market; the influence of consumer movements; and the effects of licensure regulations.

In virtually every industrial nation, professions were undergoing unprecedented turbulence (Blishen, 1991; Coburn, 1993; Freidson, 1994; Johnson, Larkin, Saks, 1995; MacDonald, 1995; Decter, 1997). A few writers incorrectly predicted the demise of professions (Haug, 1975); a greater number prophesied reorganization of existing structures (Coburn, 1993; Johnson, Larkin, Saks, 1995) Nevertheless, Freidson (1994) predicted that the shift in focus from a theoretical discourse on professional power to the social and economic influence of professional work would remain the dominant theme in evaluating professionalism today "because the high cost of health, legal, education, welfare and other professional services has become a critical policy issue" (p. 4).

In the general context of an "irreverent age" (Ostry, 1978, p. 18), certain factors can be more specifically identified which have cast the professions into sharper public focus. Most stakeholders groups, including professions, agree that control of escalating health costs is desirable. This belief has been reflected in recent health policy through a near universal preoccupation with cost-containment (Manga, 1993; Blishen, 1994; Decter, 1997; Johnson, Larkin, Saks, 1995). Whether or not this is a primary motivating force driving proposed changes in professional legislation is uncertain. What is clear is a number of other factors which are also contributory: greater formal education in the health workforce; more knowledgeable and assertive consumers who are desirous of greater access to services and greater choice in the selection of treatment alternatives; the explosive growth in the number of licensed professionals and the number of occupations seeking professional status; mounting societal complexity and the resultant increase in the demand for professional assistance and expertise; inefficiencies in professional service delivery; underutilization of less costly but competent practitioners; unremitting increases in professional service costs; overlapping of what have traditionally been exclusive practice jurisdictions; and the apparent inefficiencies of professional licensing regimes. Then, too, there has been a general shift in political values away from extensive and costly regulatory structures in favour of private initiative and enterprise (Ostry, 1978; Dolan, 1980; Haug, 1980; Rubin, 1980; Young, 1988; Tuohy, 1992; Coburn, 1993; Brint, 1994; Freidson, 1994; Sutherland, 1996).

All of these factors have coalesced over the past few decades to explain a sustained interest, if not preoccupation, in public policy and the health professions. The greatest attention has been devoted to what has become a voluminous collection of debates on the controversial issue of licensure, as the cornerstone of professional self-regulatory status. The following section is devoted to that discussion.

PROFESSIONAL SELF-REGULATION AND LICENSURE

All of the traditional health professions, generally understood to include those groups with free-standing Acts, i.e., medicine, dentistry, nursing, chiropractic, pharmacy, and others, have been granted the legislative authority or autonomy to manage their own discipline, that is, to be self-governing. There are two types of occupational regulation: licensure and certification, usually referred to as right-to-title (Bohnen, 1994). Licensure requires that an individual must obtain a license in order to engage in a practice area. This regulation, which applies to the free-standing health professions, gives members of the profession the exclusive right to provide a particular service to the public and prohibits all others from engaging in the defined practice area. It also assumes right-to-title authority. The second form of occupational regulation is certification which gives members of the profession the exclusive right to use a title but does not prohibit non-professionals from providing the service. In Alberta, all health professions governed under the omnibus Health Disciplines Act have right-to-title legislation. (See Table 2, p. 108, Health Profession Regulation in Alberta, for a list of health professions with free-standing statutes or umbrella statutes.)

Professional self-regulation is a much sought after privilege, enhancing the political, social, and economic power of an occupational group (Gross, 1988; Tuohy & Wolfson, 1978; Rottenberg, 1980; Shimberg, 1982; Gross, 1988; Freidson, 1994). Through this delegated function, self-regulating professional associations have acquired the statutory power to license, govern, and control those persons who assume membership and engage in designated activities. With the authority granted through self-regulatory status, professional associations exercise significant influence over the activities of its members. They define the professional scope of practice, acceptable standards of practice, codes of ethical conduct, and establish the boundaries of exclusive scope of practice activities. In addition, they maintain the exclusive right to discipline members by revoking, suspending, or altering the membership status of individuals who fail to comply with established standards (Tuohy & Wolfson, 1978; Young, 1988). Through a formalized system of professional credentialing, professional associations have established standards for the preparation of practitioners and requirements for licensure which ensures at least minimum qualifications for safe practice and excludes those who are unqualified. In short, professional associations have acquired the legal authority to influence substantially the terms on which the consuming public receives services—the nature of services received, who can offer the services, and the methods by which they are provided (Rose, 1983; Gross, 1988).

Forces Supporting Professional Regulation

The tradition of granting self-regulatory status to professional groups has long been considered the unquestioned right of the traditional health professions (Gross, 1988). During most of this century, the public perception of licensing, as the visible instrument of professional self-governance, has been favourable. Licensing of practitioners has always been accepted as a form of public protection; its social value has seldom been questioned (Rottenberg, 1980).

Although most writers point to the vigorous efforts of professional associations as instrumental in the successful pursuit of self-governance (Horowitz, 1980; Haug, 1980; Rose, 1983; Gross, 1988), there are at least three additional factors which have promoted and sustained a reliance on this form of professional control. First, there is a long-standing and traditional acceptance of professional self-regulation. As previously described, the roots of this tradition date as far back as the medieval guilds, when the professions formed private professional groups to advance mutual interests. In more modern times, licensing authority has been considered the unquestioned right and hallmark of a profession, thought to be the concern of only the professional individuals and organizations that were affected by them (Gross, 1988). Beyond the heritage of tradition, the unchallenged argument has been that without some type of regulation,

> the citizenry would suffer irreparable physical harm, emotional injury, or financial loss at the hands of practitioners whose lack of skill, knowledge, or ethics makes them unable or unwilling to foresee or forestall the commission of hurt to those they are supposed to serve. (Gross, 1988, p. 16)

Embedded within this description are the fundamental elements of specialized technological knowledge and skills, largely unavailable to those seeking health services. In fact, it is in regard to this latter circumstance that the system of self-governance and licensing has, until recently, met the needs of patients and the public (Olley, 1978; Ehrenreich, 1978; Freidson, 1994).

Second, the public has a need for, if not dependency on, the knowledge and skills provided by professionals, augmented by the inability to evaluate the technical merits of the services provided. Owing to both the complex and esoteric knowledge involved and to the emotional and physical incapacitation that often accompanies illness, Freidson (1994) and others concluded that patients were not in a position to be adequately informed and fully rational consumers who were capable of looking after their own interests in the medical market-place. Such a notion has persisted for some time, as noted in the earlier view of Lieberman (1978), who suggested that

> In a complex, technological society we are all at the mercy of experts. The layman cannot protect himself against the misuse of the professional's expertise, and except within the narrow bounds of our own specialties we are all laymen facing a world of diverse and mammoth mysteries. To require that we take responsibility for judging all those whose services we require is utopian; no such responsibility can exist in the modern world. (p. 90)

In fact, any reliance on consumers to identify improper professional behaviour contradicts a basic tenet that a non-professional is incapable of judging the behaviour of a professional (Manitoba Law Reform Commission, 1994; Brint, 1994). As noted by Ehrenreich (1978), the public condoned, if not welcomed, a dominant-submissive relationship with health professionals in the knowledge that gaining information necessary for self-determination was not possible. In turn, the payoff for the public was that professionals were seen to bring order to an otherwise technically complex and confusing world. It was for these reasons that Freidson (1994) further concluded that restrictive licensing which limited the patient's freedom to choose health practitioners was justified. Such justification was premised on the notion that most of the value of choice was dependent on the user's ability to assess variation in alternatives. Without adequate knowledge, the idea of choice was largely empty of practical significance (Olley, 1980, p. 78). Thus, these attitudes towards experts and expertise provided significant support for professional dominance and led to the third force, that of government sanction, if not promotion, of professional self-governance.

Each of the primary professions has wide fields of specialized knowledge and practice in a variety of settings. Ensuring the competence of individuals within the profession, therefore, has presented a challenge to government. The assumption was that both patients and government had inadequate knowledge to judge the competence of the provider or the quality of the service. Also, governments had neither the funds to educate the public nor the knowledge to monitor the scattered practice settings. Furthermore, governments were aware that peer review would be more acceptable than alternate forms of external enforcement. Thus, when faced with a supportive public who had traditionally raised little opposition and professional associations who advanced convincing claims, exerted strenuous lobby efforts and were willing to absorb the administration costs of regulation, governments welcomed the opportunity to delegate authority (and the financial responsibility) for the management of professional jurisdictions to the professional associations. In the absence of any third party interests in the financial or social aspects of the professional-patient interaction, and in the face of fairly uniform and accepted forms of service delivery, this seemed to be a reasonable policy solution. In fact, it could be described as an unusually satisfactory solution, wherein all stakeholders supported the policy direction (Tuohy and Wolfson, 1978; Lomas and Barer, 1986; Manitoba Law Reform Commission, 1994).

Issues Surrounding Licensure of Professionals

The uncritical acceptance of licensing began to lose ground in the early 1970s as research efforts brought occupational regulations, in general, into sharper focus (Trebilcock, 1978; Ostry, 1978; Gross, 1988; Brint, 1994). The earliest critics were political scientists and economists who, sceptical of the social benefits of occupational regulation, charged that licensure operated as a legally sanctioned cartel, restricting entry of would-be professionals and restraining competition among competent professionals from different fields (Stigler, 1971; Peltzman, 1976). In addition, exclusionary practices by licensing boards were being linked unfavourably to professional incomes and rising consumer costs (White, 1979; Shimberg, 1982).

In 1976 in response to growing public concern about regulatory agencies, the first 'sunset' laws were passed in the United States, and sometime later in Canada, stipulating that regulatory agencies were to be abolished according to a predetermined timetable unless they could demonstrate evidence supportive of continuation (Martin, 1980). Although these laws were later to prove ineffective in constraining regulatory practices, they had two significant effects. The public was alerted to the financial impact of licensing agencies, an awareness which coincided with the rise of consumerism and increasing interest in the cost, quality, and availability of essential services. And legislators, who had previously paid little attention to licensing practices, developed an interest in the relationship between health care expenditure and the assumptions underlying regulatory health policy. As professional regulation and licensure came under increasing scrutiny, basic assumptions were challenged.

Public Interest and the Demand for Licensure

Occupational licensure is an instrument of public policy, and is singularly and vigorously defended on the basis of public interest (Young, 1988; Rottenberg, 1980). In fact, it would be difficult to find any argument for regulatory intervention in a professional area that was not based on the theme of public interest (Wolfson, Trebilcock, and Tuohy, 1980). When campaigns are conducted either to secure the initial passage of a licensing statute, to increase entrance requirements, or to broaden the definition of professional practice, it is invariably true that professionals will argue that legislation will protect the public by excluding those considered to be "charlatans or quacks" (Young, 1988, p. 15).

Professional associations or boards protect the public interest by either screening-out those who are unqualified to practice or disciplining those who are in breech of practice standards. The goal of this 'preventive enforcement' is to exclude unqualified individuals from practising, thus reducing the likelihood of injury to the public. Associations also protect the public by monitoring the competency of members and investigating complaints received from consumers and other professionals. Licensees who do not adhere to acceptable standards of practice or conduct can be disciplined by means of a reprimand, a suspension, or the revocation of the individual's license and thus the permanent or temporary loss of the right to practice (Shimberg, 1982, p. 101).

Proponents of regulation argue that licensing assures the public that the quality of the service or product they are purchasing is maintained through the exclusion of those unqualified to practice and enhanced through the strengthening of requirements for those seeking entry to practice. Although a number of economists (Maurizi, 1974; Stigler, 1971; White, 1979) support the notion of the free-market economy, others contend that on the basis of information asymmetry, the public is not an adequate regulator of harmful conduct, particularly in relation to professional services. The lay person, it is believed, cannot protect himself against the misuse of professional expertise or discriminate between a variety of services, other than within the narrow bounds of personal knowledge or experience. Licensing requirements, therefore, assure the public that practitioners are competent to practice (Freidson, 1994).

Two theories have been advanced to explain the phenomenon of licensing. Wilson (1980) refers to the 'public interest model' in which regulation is introduced for the benefit of the public, ideally at the urging of consumers. Stigler (1971) referred to an 'acquired or economic model' wherein occupations sought to acquire regulation for their own benefit rather than public benefit. Licensure, he believed, served the economic interests of occupational groups because it became the means by which members were protected from the inherent risks of unregulated markets, an observation which Benham (1980) later referred to as "career insurance" (p. 17). Other critics of the public interest theory believe that self-interest has been and remains the primary motivator of regulatory legislation (Friedman, 1962; Benham, 1980; Hogan, 1983; Gaston and Carroll, 1983; Young, 1988). Consumers rarely engage in campaigns to license occupations. In an often quoted observation, Lieberman (1978) pointed out that although professional licensure was always articulated in public interest terms, regulation was sought by professionals rather than the public whose interests were said to be in jeopardy in the absence of such protection. Puzzled by these circumstances, Lieberman noted that "the claim to self-regulation is strange. We don't ask non-playing members of a football team to referee games involving their teams. Why, then, do we, with such nonchalance, let professionals assume similar power?" (p. 90).

The 'control' function of licensure and the inhibition of competition have attracted many critics. One of the earliest and most vocal was Friedman (1962), who attacked licensure on the ground of economic inefficiency and infringement of freedom of both consumers and providers of services. In his view, "Licensure almost inevitably becomes a tool in the hands of a special producer group to obtain a monopoly position at the expense of the rest of the public" (p. 148). Further, economic and social costs were incurred when individuals who wanted to practice were restricted from doing so, and when the public was deprived of a variety of services, some potentially less costly. At the time, Friedman was described as radical in his views; however, many of his statements have been revisited in later decades (Wright, 1978, p. 126).

Restrictions on Entry to Practice

In order to protect the public, professional licensure is intended to prevent those who are unqualified from practising in a given occupation. Thus, licensing laws typically require that practitioners meet four requirements: (a) graduation from a recognized program of study, (b) successful completion of an examination, (c) evidence of supervised experience or apprenticeship, and (d) proof of residency or citizenship (Gross, 1988; Young, 1988). Enforcement of these requirements is the responsibility of the professional association or licensing board.

Critics argued that many requirements found in licensing statutes have been historically and arbitrarily established, and are not based on evidence of minimum levels of knowledge and skill necessary to ensure adequate service (McClelland, 1973; Collins, 1979; Hogan, 1983). Historically in nursing, a diploma in nursing has been obtained at the completion of a two, three, or four year training program. Data do not indicate unacceptable performance among any of these graduands (Dolan, 1980). Collings (1988) theorized that skill requirements of jobs were largely the result of organizational politics and that credential requirements were more related to availability of manpower than job requirements (p. 175).

Once licensure regulations have been introduced White (1979) claimed that "escalator" or inflationary effects were likely to result in demands for additional regulatory requirements (p. 25). However, as Shimberg (1982) observed,

> Beyond a certain point, additional training does not mean a higher quality of service. What it may mean instead is that the practitioner can charge more for his or her service because of the long time spent in training and because the supply of practitioners may have been thinned out because of the unnecessarily long training requirements. (p. 40)

In some areas, citizenship status and residency requirements are required as a condition for licensure. Defenders of these standards argue that the practice of a profession is closely associated with the history and traditions of a jurisdiction and therefore licensees should be citizens (Young, 1988). As Shimberg (1982) has noted, residency requirements, although considered unconstitutional, at least serve as an intimidating effect on those wishing to apply for a license.

Licensing examinations have also served to restrict mobility, creating maldistributions in the supply of practitioners and inflated professional incomes. In Canada and the United States reciprocity does not exist in all areas. Professionals wishing to apply for a license to practice may be required to write a qualifying examination and seek licensure initially in an alternate jurisdiction. Several studies have also correlated restricted mobility with higher than average earnings for resident practitioners (Boulier, 1980; Kleiner et al., 1982).

Role of Licensing Boards

Although licensing bodies have been entrusted with the responsibility of protecting the public from incompetent practitioners, they have been described as more zealous in prosecuting unlicensed practitioners than disciplining licensees. Young (1988) reported that despite the increase in disciplinary actions taken by medical boards, most actions were imposed because of violations related to competitive behaviour rather than malpractice or incompetence. There have also been historic reluctance by all professional groups to provide data on disciplinary actions against members. While there is support for issues of confidentiality, critics argue that preservation of professional solidarity and public image may also be operational (Hogan, 1983). Derbyshire (1983), an authority on medical licensing, and himself a physician, has been critical of the effectiveness of medical licensing boards. He reported that in a typical year, 0.16% of physicians were disciplined. Actual evidence of unethical or incompetent physician practice was estimated to range from 2-10% (Young, 1988).

Similar circumstances have been documented in the legal profession. A report from an independent review of the American Bar Association concluded that disciplinary action was virtually non-existent, supported by the finding that in a year selected as typical, only 0.1% of lawyers were disciplined. Other evidence suggested that observed misconduct, although not reported, was much higher (Young, 1988).

Licensing boards have also been delegated the function of periodically assessing practitioner competence (Hogan, 1983; Gross, 1988). The most common vehicle has been the adoption of required continuing education credit. Weaknesses in this system have included insufficient resources to oversee mandatory programs and ambiguous grading standards. Physicians correctly charged that there was no relationship between the quality of patient care, physician performance and continuing education requirements (Derbyshire, 1983, p. 200). Shimberg (1982) observed that courses on public speaking, assertiveness training, and accountancy were primarily chosen on the basis of personal interest rather than to correct clinical deficiencies.

Effects of Licensure on Income and Costs

Friedman and Kuznets (1945) were the first researchers to document the effect of occupational regulation on entry restriction and income, concluding that incomes were disproportionate in relation to the training and skill of professionals. Trebilcock (1978) came to a similar conclusion, noting that the high cost of health services, largely related to professional incomes, seemed to reflect less than fully effective regulatory constraints on the economic behaviour of professionals. Other studies have supported a similar theme. In a study of licensed laboratory workers, income levels were found to be 16% higher than those with less mandatory regulations (White, 1980). He concluded that

> in the absence of any evidence that occupational licensure increases the quality of laboratory tests, the results [of licensure laws] suggest that policy makers should be cautious in introducing new laws, or strengthening old ones; these actions may sharply increase costs and leave quality unchanged. (p. 102)

Where jurisdictions have established non-reciprocity, dental fees have been shown to be higher than in those areas which recognized out-of-state licenses. Shepard (1978) estimated that the price of dental services and incomes of dentists were 12% to 15% higher than in non-reciprocity states, with an accumulated cost to consumers of $700 million.

Available Canadian data have yielded similar results. In a series of studies by Muzondo and Pazderk (1980) on professional groups, restrictions on advertising were found to increase earnings by one-third. Restrictions on fee competition were also found to increase income by 10% and restricted mobility increased professional income by 4%. Taken together, the net effect of these restrictions to the Canadian consumer was estimated at $350 million.

Licensing and Quality Assurance

Proponents of licensing defend professional regulation on the basis that it is the only means by which optimal standards of quality can be maintained (Dingwall and Fenn, 1987). While this assumption has, until recently, not been challenged, there is little evidence to substantiate or negate such a claim. Some evidence has supported the argument that licensing restrictions enhance quality. In a study of optometrists (Begun, 1981) and pharmacists (Martin, 1982), licensing requirements have been associated with higher quality of service. In contrast, a study comparing services performed by opticians, ophthalmologists, and optometrists revealed similarities in quality with variation in cost. Despite these studies, most evidence seems to indicate that licensing, of itself, has a neutral effect on quality (Young, 1988). Licensing regulations have been designed to ensure the public that practitioners have achieved a minimum standard of practice. However, Carroll and Gaston (1983) claimed that licensure did not guarantee that a higher quality of service would be received by the public.

The relationship between quality service and licensure remains elusive and largely assumptive. A number of studies of non-professional occupations have disputed the claim that licensed trade workers provide a better quality of service (Maurizi, 1980; Carroll and Gaston 1981; Leland, 1980). Such findings have been inappropriately extrapolated to the professions in the absence of substantiating evidence. However, Carroll and Gaston (1981) found evidence of quality service *within* specific professional and paraprofessional groups, irrespective of licensure regulations.

Licensing and Scope of Practice

One of the most contentious issues related to professional regulation is that associated with scope of practice. Licensing laws are commonly referred to as 'practice acts,' because they grant authority to licensees to engage in defined practices within a profession. Exclusive scopes of practice legally exclude anyone without a license from performing any of the defined activities. Tuohy and Wolfson (1978) noted that professions may define an exclusive scope of practice more broadly than is warranted by its specialized knowledge base, thus inhibiting a rational and cost-effective allocation of functions in its sphere (p. 116). Alternatively, practice acts can be very definitive such that legal determination is necessary to determine if performing a particular task constitutes a violation. Using the common example of providing medication, medical acts stipulate that only physicians may "prescribe" or "furnish" drugs; pharmacy acts authorize pharmacists to "dispense" drugs; and the nursing practice acts allow nurses to "administer" them. Aside from a matter of semantics, interpretation of these directives affects the behaviour of health personnel (Roemer, 1970, pp. 48-49). Thus, the conclusion by Trebilcock (1978) and others has been that exclusive licensing regimes have been used "too pervasively and indiscriminately in the past . . . suggesting greater caution in its use than has hitherto been the case" (p. 11).

It has been the concerns over escalating health care costs which have generated interest in the use of paraprofessionals. However, since the allocation of manpower has been closely linked to scopes of practice, realignment of the workforce has remained largely unchanged (Ontario Commission on the Healing Arts, 1970; Castonguay, 1978; Tuohy, 1994; Sutherland, 1996). As Hogan (1979) noted,

> By defining in extremely broad terms the practices restricted to fully licensed practitioners, and by making no provision, or very rigid or narrow provisions, for delegating functions to others, licensing laws unnecessarily limit those who can provide auxiliary services. (p. 277)

There is substantial evidence that alternate practitioners can provide cost-effective and safe service provision within specific parameters. A Canadian government survey of dental practice showed that as much as 80% to 90% of the work performed by dentists could be performed safely by auxiliary practitioners with approximately 20 months of related training. Although the effectiveness of dental nurses in remote areas of northern Saskatchewan was unchallenged, the program disappeared due to the opposition of the Saskatchewan Dental Association (Boase, 1994; Sutherland, 1996). Another study estimated that dental care costs in Ontario could be reduced by 40% if dentists were to make optimal use of paraprofessional (Evans, 1980). Paraprofessional training for those providing health services in the military have historically been of shorter duration than for civilians, without compromising quality (Arnhoff, 1971; cited in Hogan, 1983, p. 128). Lave and Lave (1970) estimated that 80% of pediatric practice could be done by practitioners with lesser training than pediatricians.

The demonstrated acceptance of the nurse as a primary health care practitioner in the United States and Canada has been the subject of much discussion, recommendation and conclusive evidence (Health and Welfare Canada, 1971; Spitzer and Kergin, 1971; Boudreau, 1972; Spitzer, 1978; Sutherland, 1996). In a Canadian study by Spitzer (1978), in which nurses and physicians were co-practitioners, the cost of care was reduced, quality of care was maintained, and patients were satisfied. Other studies have found that physician assistants were able to provide quality care for elderly populations and disenfranchised groups (Young, 1988). And Scandinavian studies have demonstrated that increasing the regimen of standard preventive procedures which can be performed by dental hygienists reduced the incidence of dental caries and periodontal disease (Dolan, 1980).

The effective utilization of these practitioners has been restricted largely because of the legal and traditional implications of medical practice acts which identify the diagnosis and treatment of illness as the exclusive right of physicians (Storch, 1994). Further, independent practice is hampered by the legal requirement that many non-physician practitioners, i.e., nurse practitioners and physician assistants, are required to work under the supervision of a physician or other designated professional (Leitch & Mitchell, 1977; Sullough, 1978), and reimbursed on the basis of substitute, rather than add-on service provision. This latter circumstance has rarely been satisfactory to physicians, and has been projected to remain a restriction under existing fee schedules (Tuohy, 1992; Boase, 1992; Manga, 1993; Decter, 1994). Similar requirements apply to dental hygienists and denturists. Such requirements have effectively eliminated independent practice, particularly intended for service provision in rural and remote areas and for disadvantaged populations (Dolan, 1978).

Debates over the utilization of alternate professionals and extended practice have spanned decades, leaving an observer to ponder over the reticence in light of the evidence. Perhaps Dolan (1978) came the closest to capturing the spirit of the explanation when he stated,

> Many legislators simply do not wish to take the personal responsibility for adverse results and therefore take the path of greatest confidence—the status quo. Virtually no one is willing to abolish licensing laws; and having conceded this, one is left in the quagmire of line-drawing in scopes of practice, supervisory requirements, and barriers to entry. (p. 239)

CHAPTER SUMMARY

The opening section of Chapter 2 defines policy analysis, describes the design of effective policy research, particularly those considerations related to prospective policy analysis design, and the application of these concepts within this study. Dunn's Model of Policy Analysis (1981) provides the framework within which proposed elimination of the exclusive scope of practice clause from nursing legislation can be conceptualized as a public policy issue in Alberta. The three components of the model—the stakeholders, the policy environment and the related public policies—were discussed in relation to those influences which have or are contributing to the current proposed change to existing health profession legislation.

The three groups of policy stakeholders were identified as the health professions, government policy-makers and the public as the consumer of health services. The discussion of the health professions highlights the importance which professions attach to self-governance and exclusive practice areas. Historically, a small number of autonomous professions have controlled large practice areas. However, the emergence of new health profession groups has precipitated changes in interprofessional relationships and stimulated a changing policy environment.

The primary purpose of health profession regulation is the protection of the public interest. The discussion of this premise included the basic assumptions on which this purpose is based. The argument most repeatedly advanced is that some form of regulation of health professionals is necessary to protect the consumer of health care who, because of lack of knowledge, is unable to evaluate practitioners or the services provided. The collective public interest was also described in relation to the necessity of ensuring that resources are allocated in a technically and resource-efficient manner for populations. It was in this regard that governments rather than professions were seen to possess knowledge of resource consumption by the aggregation of patient-professional encounters and the distribution, roles and incentives of the overall health care system.

Policy-makers as stakeholders were seen to be central to the introduction of proposed changes to health profession legislation. Concerns over rising health care costs and the proliferation of health professions have prompted a number of provincial governments to commission reviews of existing legislation. The earliest of the these reviews was the Castonguay Commission in Quebec and the Commission on the Healing

Arts in Ontario, initiated shortly after, and prompted by the passage of the national *Medical Care Act* in 1966. Each of the commissions struggled with the need to reconcile the conflicting issues of professional self-regulation, government control, and the public interest. The resulting legislation, the *Professional Code* (1973) in Quebec and the *Health Disciplines Act* (1974) in Ontario, reflected modifications to professional self-governance authority and revisions to exclusive practice jurisdictions. With apparent disappointment in the outcome of the legislative changes in Ontario, the Health Professions Legislative Review was established in 1982. Nine years later the resultant *Regulated Health Professions Act* depicted a marked change from previous legislation with the elimination of exclusive practice jurisdictions and the introduction of thirteen 'controlled' acts. This model has been viewed with interest in other provinces and is evident in the proposed legislative changes in Alberta.

The discussion of the policy environment surrounding health profession legislation highlighted the jurisdictional disputes which have characterized inter-professional relationships as scopes of practice expanded and overlapped. While the medical profession has been tenacious in their resistance to intrusions within their exclusive jurisdiction, an increasingly well-educated cohort of professionals has challenged this claim. The resulting issue has been the increasing conflict between professional groups within a fundamentally changing environment, motivating governments to bring about rational planning to a complex and historically resistant problem.

Discussion of health policy focused on the evolution of policy strategies as they have been transposed from a pluralist to corporatist approach. The pluralist approach to policy-making, largely reflecting the outcome of competition among professional interest groups, was seen to dominate the policy environment resulting in uncoordinated policy directions. More recently, governments were becoming more proactive in establishing long term policy directions. The corporatist model was described as reflective of the cooperative involvement of all interest groups and a more balanced relationship between the health care sector and government.

The second section of the chapter provides an overview and description of the process by which occupations achieve professional status and the more recent shift in the conceptualizations of professions. Sociologists have generated a large body of literature in attempting to define an ideal profession. The dominant theme of these writings seemed to converge around three defining characteristics: specialized knowledge, autonomous practice and an altruistic view of patients. After decades of inconclusive debate over definition, attention was directed towards the process by which occupations become a profession. Occupations in pursuit of professional status were seen as progressing through a series of predictable stages: defining a jurisdiction, establishing a professional association, initiating education programs, establishing standards of practice and codes of ethics and licensing requirements and ultimately achieving the authority of self-governance over an exclusive practice area.

Through the process of professionalization, professional groups became the controllers of expert knowledge and areas of practice. Professional associations evolved steadily into influential organizations, becoming the formal and collective means by which the interests of its membership and the public interest were expressed. They defined professional scopes of practice, codes of ethics, and claimed the right to exclude those who were unqualified from practising within a defined area. Standards of practice, together with the authority to influence labour markets by means of credentialing and licensure requirements, combined to shape the pursuit of professional autonomy and self-governance.

One of the striking features of the politics of professions was the rapidity with which views appeared to change. Beginning in the 1970s, professional power replaced expertise as a central theme in the literature. Economists noted the closed, monopolistic character of the professionalized labour market and political scientists were conceptualizing professions as privileged private governments. And policy-makers were portraying the process of professionalization as insular in its vision of what was perceived as good for the public. Attention shifted from an interest in professional norms and role relations to an analysis of professional control over the work place and the role of power in maintaining such control.

In more recent decades, the theme of professional power has been redirected at the social and economic influences of the professions. Professions have become exposed to public scrutiny in relation to their numbers, their costs, and their benefits. Shifts in the ideological climate have lead to pressure to reduce professional control over the allocation of practitioner functions, often sustained by exclusive licensing. Proponents of licensure laws have argued in support of the necessity to ensure a certain quality of professional service and to protect the consumer from fraud and incompetence. Others questioned their purpose and utility.

The final section of the chapter provides a description of professional licensure as background to the emergence of professional regulation and exclusive practice areas. The discussion includes a review of the substantial literature on occupational licensure, much of which cites a variety of research studies conducted primarily by economists and sociologists who challenged the underlying assumptions of regulatory practices. In this body of literature, professionals have rarely been ‘heard from.’ However, the consensus of the published views is that licensure is almost always sought by professionals, creates barriers between professions, is not directly related to the quality of service, unnecessarily restricts service provision and increases health care costs.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

Chapter 3 provides a detailed description of the theoretical framework, research design, data collection and data analysis procedures utilized, and a description of the process of conducting the research. Decisions made in the data collection and analysis process are identified, and the rationale underlying each decision is described. Validity, reliability and generalizability of the findings are discussed, along with a description of the specific measures taken to address these elements. The ethical considerations implicit in the study, and strategies adopted to address these considerations are addressed.

CONCEPTUAL FRAMEWORK

The conceptual framework of this study embodies the concepts of prospective policy analysis. The specific model utilized as the framework is an application of Dunn's (1981) Model of a Policy System to the issue of eliminating the nursing exclusive scope of practice and identification of policy alternatives for resolution of this issue. Figure 1 is a diagrammatic representation of the conceptual model.

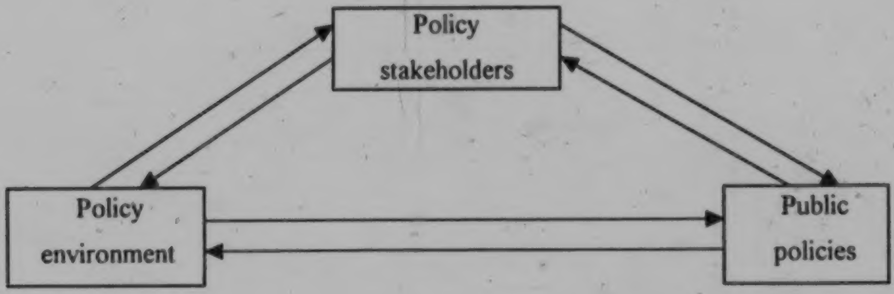

Figure 1. Three elements of a policy system (adapted from Dunn, 1981, p. 46)

In Dunn's (1981) model, a policy system is described as the overall institutional pattern within which policies are made, including the interrelationships among three elements: public policies, policy stakeholders, and policy environments. *Public policies* are a series of related choices, including decisions not to act, which are made by government in response to public issues. A policy issue is the result of diverse definitions of a policy problem, and is influenced by actual or potential courses of government action that involves conflicts among different segments of the community. The definition of a policy problem is shaped by *policy stakeholders;* that is, individuals or groups that have a stake in the policies as they affect and are affected by governmental decisions (pp. 46-48). Examples of policy stakeholders are elected leaders, labour groups, citizen groups, political parties, government agencies, professional associations, and consumer or client groups. A *policy environment* is the specific context in which events surrounding a policy issue occur. This context is influenced by policy stakeholders who may define policy problems differently in response to perceived policy environments.

In the context of this study, public policy refers to the current proposed change to the *Nursing Profession Act*, and the variety of legislated changes which have been a precursor to the proposed change. Policy stakeholders are those individuals and groups with a vested interest in the proposed legislative change. The policy environment is the historical and socio-political context which is influencing the policy issues. Each of these elements formed the basis for the research questions and the framework for data analysis.

STUDY DESIGN

This study was designed as a qualitative case study of the issue of elimination of the nursing exclusive scope of practice. As Dunn (1981) noted, an issue case study deals primarily with the formulation of a problem and possible solutions, and only rarely reaches definitive conclusions (p. 362). Case studies generally form the first phase of an in-depth policy analysis and include the background of the problem, the perceptions of the significance of the issue in a policy context, description of the issue, analysis of the issue, and development and analysis of possible solution (p. 363).

Yin (1984) characterized case studies as empirical inquiries that used multiple sources of evidence to investigate complex phenomena within their real-life contexts. According to Gay (1987), case study research is a particularly useful methodology to determine the relationships among factors that result in the current behaviour or status of the subjects of the study. Thus, its purpose is "to determine *why*, not just *what*" (p. 207). There are four characteristics of a case study which are central to this objective. First, case studies are *particularistic*, having a specific focus on a process. Second, case studies are *descriptive*, providing a rich, "thick" description of the phenomenon under study. Third, case studies are *heuristic* in that they illuminate an understanding of the phenomenon under study. And fourth, case studies are *inductive* in that generalizations, concepts, or hypotheses emerge from an analysis of data (Merriam, 1988, pp. 12-13).

Case study research has proved particularly useful for the analysis of policy formation. In describing the strengths of this type of research, Lincoln and Guba (1985) noted that case study research facilitates an understanding of human action and interaction within given contexts. Since a change process is fundamental to policy analysis, case studies are, according to these researchers, "better able to assess social change than more positivistic designs (p. 33)."

One must also recognize certain limitations in the use of case study research. Although a rich, thick description and analysis of a phenomenon may be desired, the time or money for such an undertaking may be limited. Merriam (1988) cautioned that the amount of data selected for analysis may lead the reader to erroneous conclusions which overly simplify or exaggerate a situation. Thus, as the principal instrument of data collection and analysis, the researcher is reliant on personal sensitivity and integrity to guide the investigation. An additional limitation is related to the "unusual problems of ethics" wherein a researcher could select from among available data only that information which is supportive of a particular position (p. 34). Careful design of the study and external review of data analysis and conclusions were recommended as assisting in the control of these limitations (p. 36). A final limitation is related to the political nature of case studies.

> At all levels of the system, what people *think* they are doing, what they *say* they are doing, what they *appear* to others to be doing, and what in fact they *are* doing, may be sources of considerable discrepancy. (MacDonald & Walker, 1977; as cited in Merriam, p. 34)

DATA COLLECTION METHODOLOGY

Data were gathered by document analysis and semi-structured interviews. The investigation focused on obtaining factual information, opinions, and perceptions of key informants representing the nursing profession; the Departments of Health, Labour, and Advanced Education and Career Development; and the public.

Interviews

Semi-structured interviews were conducted with all participants. In recommending this form of data collection, Borg and Gall (1983) claimed that "it provides a desirable combination of objectivity and depth and often permits gathering valuable data that could not be successfully obtained by another approach" (p. 442). Similarly, LoBiondo-Wood and Haber (1998) supported this methodology as a means of collecting richer and more complex data by allowing the interviewer the opportunity to probe for greater understanding of a particular response.

According to Morse and Field (1995) three sources of error affect the validity of data collected through interviews. The attitude or predisposition of the respondent will directly affect the quality of the response. They suggest that careful attention to the design of the study and the format of the interview will eliminate or minimize the effect of respondent predisposition. Similarly, the predisposition of the interviewer, involving confidence, ability to establish rapport, and recognition of stereotyped expectations of people and their responses can bias data collection. The explanation of the study, techniques utilized to achieve respondent comfort and openness, and the conduct of the interview itself affect the validity of the data collection. Finally, interview bias wherein the interviewer unwittingly leads the respondent to answer questions in a certain way is a possibility, particularly in an unstructured interview. In this regard, interviewer awareness of non-verbal responses to participant comments increases the validity of the methodology.

Document Analysis

Relevant literature and government documents were subjected to the process of document analysis. In what Strauss and Corbin (1990) describe as a constant comparative method, data are continuously compared with other data for evidence of similarities and differences. According to these researchers, this process of cross-validating research findings is a recommended method to increase the level of confidence in the validity of the data.

Concerns of validity, reliability, and generalizability of collected data are associated with document analysis. Validity and reliability are related to the accessibility of information, the representativeness of the information collected, and possible biases in the interpretation of responses. Generalizability is related to the context in which the data were generated, and determination of whether the responses were unique to a participant or reflective of a broader perspective (Strauss & Corbin, 1994).

THE DATA COLLECTION PROCESS

Data were collected through literature and document analysis, and through participant interviews in three distinct phases.

Selection of Respondents

Fourteen participants were chosen by a purposive sampling technique, that is, the individuals chosen were those who the researcher believed were the most knowledgeable in the field of health profession legislation and regulation and were aware of the proposed *Health Professions Act*. Each study participant was selected from one of four stakeholder groups considered to be central to the elimination of the exclusive nursing scope of practice from existing legislation. The following section describes the four stakeholder groups and the participants selected within each group.

The Nursing Profession

Determining which health profession groups to include in the study presented difficulties for the researcher. The concern was that by focusing on one profession an incorrect assumption could be made that proposed legislation changes applied only to the nursing profession when in fact proposed changes were uniformly applied to all health profession legislation. However, there was a necessity to limit the study to ensure its completion within the time and resources available, but also a need to ensure that the study resulted in a full description and analysis of the issue of eliminating the exclusive nursing scope of practice. Thus, the nursing profession was chosen from amongst thirty-one health professions for several reasons. First, this group is the largest health professional group and is characterized by strong and diverse interest groups representing practitioners, educators, researchers, and administrators, and also by a vocal and influential union organization. Second, the nursing profession has a long and well documented history of regulatory changes including the achievement of exclusive practice legislation. Third, the nursing exclusive scope of practice was functionally different from the other seven health professions with similar legislation. Fourth, the researcher is familiar with and was involved previously in health profession legislation discussions pertaining to this discipline. And, fifth, because of the traditionally broad and non-definitive scope of nursing practice, this profession may experience greater role transition because of the proposed changes in health profession legislation than would other professional groups.

Seven nursing participants were chosen to participate in the study. These individuals represented the professional nursing association, nursing unions, educational institutions, and practice settings and were selected on the basis of their knowledge of existing and proposed nursing legislation. Each of the participants had been actively involved in the nursing profession at the time the exclusive nursing scope of practice was instituted in 1984, and most had been involved in, or were knowledgeable about, other discussions concerning nursing legislation prior to or following that period of time. All of the potential interviewees who were initially approached agreed to participate in the study.

Licensed Practical Nurses

One representative of the Professional Council of Licensed Practical Nurses was chosen to participate in the study. The licensed practical nurse group was included in the study for two reasons. First, the registered nurses and the licensed practical nurses have held complementary roles since the late 1940s. Since that time, the scope of practice of licensed practical nurses has expanded to include tasks traditionally considered within the scope of practice of registered nurses. Some of these tasks include taking temperatures and blood pressures and more recently, administering oral medications. This circumstance has been of concern to the Alberta Association of Registered Nurses. And, second, with the proposed elimination of the nursing exclusive scope of practice and the introduction of restricted activities, these concerns have escalated amongst registered nurses. The concern is that licensed practical nurses will assume a larger portion of the scope of practice of registered nurses. Thus, because of this background and the proximity in which these two groups practice, it seemed prudent to include a representative of the Professional Council of Licensed Practical Nurses in the study.

Government Representatives

Three participants, each representing one of the Departments of Health, Labour, and Advanced Education and Career Development, were selected to participate in the study. The Department of Health is officially responsible for legislation governing six health professions with free-standing statutes, one of which is the *Nursing Profession Act*. Therefore, a bureaucrat from the Department of Health who was the spokesperson for the Nursing Profession Act was selected to participate in the study. The Department of Labour is responsible for legislation governing the remaining eight free-standing health profession statutes and the umbrella Health Disciplines Act. The participant chosen from the Department of Labour was included because of her long-standing involvement with health profession legislation dating back to the introduction of the exclusive nursing scope of practice to the *Nursing Profession Act*. The Department of Advanced Education and Career Development has traditionally been represented in discussions pertaining to health professional legislation because of its mandate to approve funding for educational programs and to approve credentialling requirements for entry to practice in all health professions. The participant chosen to represent this department was an individual with extensive government and educational administration experience related to the registered nurses, the licensed practical nurses and other allied health groups. This individual had also been a member of the Health Workforce Rebalancing Committee which had been established by the Ministers of Health and Labour in 1994 and given a mandate to oversee changes to existing health profession legislation and to recommend changes in funding allocations.

Public Representation

Since the fundamental purpose of health profession legislation is to protect the public interest, it seemed essential to incorporate a public perspective. The difficulty was to identify individuals who had substantial knowledge about health profession legislation, were knowledgeable on the proposed Health Professions Act, yet were non-practising professionals who could provide a public and non-partisan perspective. Three participants were chosen to represent this perspective. The first participant was an individual who had recently retired from a lengthy career in health service administration. The second participant was a well-known public figure, highly regarded as a former Cabinet Minister, and influential as a member of a number of commissioned provincial health studies. The third participant was a prominent, non-practising physician, with experience as an educator, administrator, and policy advisor. Although a two-month wait was required to meet with the latter participant, it was felt that the perspective which this individual would contribute warranted the delay.

Document Analysis

Documents and current literature related to the historical and current status of health profession legislation in Alberta were selected and reviewed. Government documents, government and professional position papers, journal articles, published books and conference proceedings related to the historical development of professionalism and the emergence of health profession legislation, the proposed changes to the Health Professions Act, and the issues surrounding these proposed changes were initially reviewed to establish a background for the study. These published perspectives on factors affecting the issue of eliminating the exclusive nursing scope of practice formed the basis for the interview schedule. Recently published newspaper articles and reports were reviewed and incorporated into the findings. The findings of the document analysis are reported in Chapters 3 and 4.

During each interview, the professional and government participants were asked if any relevant institutional documents, position papers or minutes of discussions were available which reflected the perspective of the organization the interviewee represented. Both official and unofficial documents were provided by the respondents if such were available. Analysis of these documents is incorporated into the data analysis of each stakeholder group response as presented in Chapters 5 and 6.

Pilot Interviews

The data obtained from the literature and document review formed the basis for a pilot interview with a nurse who had substantial experience with health profession legislation, and informal conversations with a senior official from the Department of Labour and the Department of Advanced Education and Career Development. These interviews established that the elimination of the nursing exclusive scope of practice was a significant issue in the province and provided additional information on the aspects of this issue which required assessment in the study. A growing demand from employers and the public for revisions to existing health profession legislation was identified. Barriers to the efficient allocation of health professionals was seen as a major concern in the province, particularly in terms of the capability and interest of employers and government in ensuring the effective utilization of health professionals at reasonable cost. The existing exclusive practice jurisdictions was seen as unnecessarily restrictive in relation to many tasks and processes; such an approach generally exceeded the intention of public protection. However, these respondents believed that the health professions were not of a single mind about the need for and the desirability and feasibility of shifting from an occupational to a task-based model of regulation.

The Interview Process

The format of the interviews reflected the major research questions and the factors identified from the literature and document review which were related to the issue of eliminating the exclusive nursing scope of practice. An effort was made to ensure that each of the participants was asked to respond to the same basic questions. The question focus was modified slightly for the respondents representing the public perspective since this group did not have an in-depth understanding of historical factors related to the introduction of exclusive nursing legislation. The focus of questions also changed slightly for the interviews conducted with government bureaucrats so as to better address the issues which had been generated in previous interviews. The formats for the interviews are provided in Appendices A through D.

Phase 1 Interviews

The first phase of interviews was conducted with the seven participants representing the nursing profession group and the one participant representing the Licensed Practical Nurse group. These participants were chosen as the initial group of interviewees in order to obtain as complete a description as possible of the historical factors which had influenced the introduction of exclusive nursing legislation in 1984 and to obtain a full description of the current issues in relation to proposed changes in legislation. No difficulties were encountered with arranging interviews within a reasonable time frame. All respondents agreed that the interviews could be tape-recorded, and subsequently signed release forms granting permission to use the data from these interviews. Since some of the interviewees did not wish to be personally identified it was decided to identify participants by a pseudonym.

The interviews were conducted in accordance with the order of questions on the interview schedule. Several of the participants had prepared written notes which they referred to during the interview. Although all participants provided responses to all questions, some aspects of the interview were emphasized more by one respondent than another. All respondents provided additional information in responding to the interview questions, and volunteered their perception of apparent differences in perspectives between the registered nurses and the licensed practical nurses. Several participants recommended additional documents which the researcher might find useful.

For the most part, the first two groups of questions, that is those which pertained to the historical background and those pertaining to issues surrounding the elimination of the nursing exclusive scope of practice were answered directly. In relation to the last group of questions, that is, those which pertained to alternate solutions to removing barriers to practice between different professional groups, participants became much less grounded and direct in their responses. All of the participants tended to discuss their perception of a desirable future for the nursing profession rather than focusing on specific questions related to alternate models of health profession legislation.

The findings of these interviews are reported in Chapter 5.

Phase 2 Interviews

The second phase of interviews included those participants who were selected to represent the public interest. No difficulties were encountered in arranging interviews with two of these participants. The third interview in this group took place at a later time in accordance with the availability of the participant.

All of the participants asked that their responses be considered their personal opinion, although one participant felt his views also reflected that of the professional group of which he was a member. All were willing to have the interview tape-recorded, and subsequently signed the release forms permitting the researcher to utilize the data. Since one of the participants was not comfortable in being identified by name, it was decided that all participants in this group would be identified by a pseudonym. No additional documents were referred to during this phase of data collection.

The format for the interviews with this group reflected the basic research questions developed for the study with the exception of those questions pertaining to the historical development of exclusive nursing legislation. The questions primarily related to the issues surrounding exclusive scopes of practice and the desirability and feasibility of removing the barriers to practice between professional groups and their personal view of other models of health profession legislation. Although this group was aware that the focus of the study was on the elimination of the nursing exclusive scope of practice, each participant acknowledged a preference to speak in terms of health professions as a collective rather than restricting comments to one discipline.

The findings of these interviews are reported in Chapter 6.

Phase 3 Interviews

The participants representing the Departments of Health, Labour, and Advanced Education and Career Development were the last group to be interviewed. The interview questions were modified slightly in relation to the data collected in Phase 1 and Phase 2.

In these interviews the researcher focused on specific questions as to the particular Department's view of the major issues regarding eliminating the nursing exclusive scope of practice which had been identified by the nursing and public representatives. Because all of the participants were very familiar with nursing legislation, they were able to focus their comments on the nursing profession. However, all of the participants made reference to the commonality of issues relative to all those professions with exclusive scopes of practice.

At the time the participants were contacted to participate in the study, they seemed more comfortable in having their responses remain anonymous. They indicated their views would reflect that of the Department they represented unless otherwise noted. No further concerns were expressed about confidentiality of information. At the time of the interview, participants signed the consent form granting the researcher permission to use the information contained in the interview transcripts with the understanding that they would be identified by a pseudonym in the reporting of the data analysis.

The findings of Phase 3 interviews are reported in Chapter 6.

Data Analysis Procedures

Both the transcribed interviews and the documentary data were subjected to content analysis procedures. Categories for data reporting and analysis were developed based on the conceptual framework and the research questions. Sub-categories in each data collection phase varied slightly due to the particular perspectives of the participants. The major data reporting categories and the sub-categories in each were as follows:

1. The History of the Introduction of Exclusive Nursing Scope of Practice Legislation

This category reflected the component of public policies as one of the three elements of Dunn's Model of a Policy System. The sub-categories include the circumstances surrounding the introduction of the exclusive nursing legislation, how the exclusive practice clause was interpreted to other health disciplines, and the expressed position of stakeholders in relation to the exclusive legislation. This data category was primarily addressed to the nursing and government participants, since the public participants did not have a detailed knowledge of the historical development of exclusive nursing legislation.

2. Perceptions of the Desirability and Feasibility of Eliminating the Nursing Exclusive Scope of Practice

This category reflected the element of policy stakeholders as included in Dunn's Model of a Policy System. The sub-categories included perspectives on the adequacy of existing legislation, the socio-economic factors associated with the elimination of exclusive legislation, and the expressed positions of the nursing community and other stakeholders in relation to the elimination of exclusive scopes of practice.

3. Alternate Models for Removing Barriers to Practice Between Health Professions

This category reflected a synthesis of what Dunn described as the policy environment. Respondents' perspectives on alternate models of policy solutions to respond to the issue of removing exclusive practice jurisdictions and the desirability and feasibility of these alternate models for implementation in Alberta formed the basis for this category.

These data categories and the content analysis were reviewed by the researcher's thesis advisor. This review assisted in verifying that the choice of content for the data categories and the reporting style were accurate reflections of the interview responses. These data categories formed the framework for the report of the findings of the nursing participants in Chapter 5, the government and public participants reported in Chapter 6 and the summary of findings reported in Chapter 7.

Comparative Analysis

Comparative analysis of the interview and documentary data was conducted throughout the data collection process, in the data analysis conducted at the end of each phase of interviewing, and determining the synthesis of data forming the final aspect of data analysis. As described by LoBiondo-Wood and Haber (1998) this constant comparative method allowed the researcher to assess the frequency of responses or events which assisted in the identification of the significant elements in the policy system. The utility of this method as described by Viera and Pollock (1988) is to enable researchers to avoid bias, check facts, examine their data for consistencies and inconsistencies, and discover the most salient features of their research settings (p. 219).

The researcher's advisor assisted in the comparative analysis process through review of findings, identification of issues, and perspectives which required further exploration as interviews evolved and the document analysis and literature review progressed. This process increased the confidence of the researcher as to the accuracy and completeness of the data collection and analysis. Comparative analysis also assisted in the development of the research questions, the development of data reporting categories, and in determining the potential of feasible solutions to the issue of eliminating the nursing exclusive scope of practice legislation.

Validity and Reliability Considerations

The focus of qualitative case study research is to attempt to make sense of or interpret phenomena in terms of the meanings informants bring to them (Denzin & Lincoln, 1994). Merriam (1988) stated that "if *understanding* is the primary rationale for investigation, the criteria for trusting the study are going to be different than if discovery of a law or testing a hypothesis is the study's objective" (p. 166). Thus most writers argue that qualitative research, because it is based on different assumptions about reality, should have different conceptualizations of validity and reliability. Although lists of specific criteria vary slightly (Lincoln and Guba, 1985; Leininger, 1994; Morse and Field, 1995), the general themes of credibility, transferability and dependability persist as criteria for judging the scientific rigor of qualitative research.

Stake and Trumbull (1982) believed that the validity or trustworthiness of case study research involved plausibility, consistency, interconnectedness, and accurate detail.

These aims could be achieved by "including procedures in the research design to corroborate information, checking accuracy of perceptions and insights, and validating the thick description of the data against the judgments of knowledgeable, multiple sources" (p. 4). Smith and Glass (1987) noted that "logical validity" was evident if "conclusions have a convincing and carefully reasoned connection with the descriptive data" (p. 278). Reality, according to Lincoln and Guba (1985), is a multiple set of mental constructions. The validity or truth of a case study therefore rested on the investigator's "adequately representing those multiple constructions or perspective" (p. 296). Thus, for the case study researcher, validity is enhanced to the extent that descriptions capture and portray the world as it appears to the people in it (Merriam, 1988). In this portrayal, what *seems* true is more important than what *is* true as the researcher presents an honest rendering of how informants actually view themselves and their experiences (p. 168).

Several strategies are suggested to further enhance the validity of qualitative studies. As described by Patton (1990), comparative analysis, or the triangulation of multiple data sources, allows the researcher to validate information by corroborating reports of respondents with other written evidence. He concluded that "the preponderance of judgement by experienced researchers is that it is worth using multiple methods, comparison analysis, and convergent validity checks to enhance the quality and credibility of findings" (p. 157). Triangulation or comparing, contrasting and verifying information collected from a variety of informants and sources obtained through a variety of methodologies were identified as enhancing the trustworthiness of the findings (Morse and Field, 1995). Lincoln and Guba (1985) encouraged the use of member checks as a means of enhancing the plausibility of the interpretations. Long-term observation at the research site, repeated observations and discussions of the same phenomenon and gathering data over an extended period of time were identified by Merriam (1988) as research practices which enhanced the validity of observations and findings.

Reliability, in the traditional sense, is concerned with the replicability of findings. However, Merriam (1988) believed the term, *reliability*, was something of a "misfit" when applied to case study research (p. 172). As Merriam described it,

> Because what is being studied is assumed to be in flux, multifaceted, and highly contextual, because information gathered is a function of who gives it and how is was obtained . . . achieving reliability in the traditional sense is not only fanciful but impossible. (p. 171)

Thus, Lincoln and Guba (1985) advised that the dependability or consistency of the results obtained from qualitative data was more reflective of scientific rigor than was the replication of findings by an outside source.

The external reliability or dependability of data could be enhanced through the use of several strategies. LeCompte and Goetz (1982) advised the researcher explain the assumptions and theory behind the study, the researcher's position in relation to the group being studied, the basis for selecting informants and a description of them, and the social context from which data were collected (pp. 214-215). The use of multiple methods of data collection and analysis and the process of triangulation strengthened reliability as well as internal validity according to Merriam (1988). The use of an audit trail which described in detail how data were collected, how categories were derived, and how decisions were made throughout the inquiry were described by Lincoln and Guba (1981). With this detailed description of the methodology, other researchers could then use the report "as an operating manual by which to replicate the study" (LeCompte & Goetz, 1982, p. 40).

The extent to which the findings of a case study can be generalized to other situations continues to be the subject of debate. As Merriam (1988) noted, "One selects a case study approach because one wishes to understand the particular in depth, not because one wants to know what is generally true of the many" (p. 173). Although thorough knowledge of the particular allows one to see similarities in new contexts, Kennedy (1979) believed that "generalizability is ultimately related to what the reader is trying to learn from the case study . . . and should be left to those who wish to apply the findings to their own situations" (p. 672). To facilitate the reader's interpretation, external validity can be enhanced by "providing a rich thick description" so that anyone interested in transferability has a base of information "appropriate to the judgment" (Lincoln & Guba, 1985, p. 124).

Measures to Enhance Scientific Rigor

There were a number of strategies utilized to increase the validity of the study. A semi-structured interview format was developed based on the literature and document review. All interviews were tape-recorded and a verbatim transcript was produced for each. An abstract describing the intent of the research study along with the rationale on which the participant had been selected was discussed with each participant at the time of initial contact. This discussion was followed up with a copy of the research questions sent to each participant in advance of the interview meeting.

The content analysis procedures applied to both documents and recorded interviews involved development of coding categories which were consistent with the conceptual framework and the research questions. The categories, a selected sample of verbatim transcripts, and the report of the findings were reviewed by the researcher's advisor to verify their validity. In order to enhance the accuracy of the data, with minor exceptions, all of the information provided by the interviewee was included in the data analysis, and direct quotes were included in order to capture accurately participant responses. A comparative analysis process was continuously utilized throughout the study and the similarities and differences were included in the data analysis and the concluding study reflections.

A detailed description of the context in which the study was conducted, including both historical and contemporary factors, and a full description of the design and conduct of the study were the measures used to increase reliability or dependability of the findings. The description of the assumptions and theory underlying the study, the political and socio-economic context of the participant environment, the description of the strategies used for decision-making in data collection and data analysis, and the description of the coding categories and conceptual framework were regarded by the researcher as the appropriate means to increase the reliability of the study. The cross-validation of the findings with the document and interview data by the researcher's advisor was utilized to further enhance the dependability of the findings.

Given that the study provided a comprehensive description of the context in which the study occurred, the selection of respondents, and the data collection and analysis of procedures, the reader or user generalizability, as Merriam described it, was as best left to those who wish to apply the findings to their own situations (Merriam (1988). In this regard, Patton (1990) suggested that the findings of case study research should "provide a perspective rather than truth, empirical assessment of local decision makers' theories of action rather than generation of universal theories, and context-bound information rather than generalizations" (p. 490). It was not the intention that the findings of this study be generalized to comparable situations, but rather to understand the "particular slice of life" under study (Guba and Lincoln, 1982, p. 236). Thus, the extent to which the findings can be transferred to another setting could be ascertained only after the degree of fit has been assessed.

ETHICAL CONSIDERATIONS

Merriam (1988) advised that ethical dilemmas in qualitative research were most likely to occur during the collection of data and the dissemination of findings. In particular, these issues were:

> 1. the researcher becoming involved in the issues, events, or situations under study
> 2. problems with maintaining confidentiality of data
> 3. problems stemming from competition between different interest groups for access to and control of data
> 4. problems concerning publication, such as the need to preserve the anonymity of subjects
> 5. problems arising from the audiences being unable to distinguish between data and the researcher's interpretation. (p. 179)

This study was designed to conform to the ethical guidelines established by the University of Alberta Faculty of Graduate Studies and Research and by the Department of Educational Policy Studies. Consent to tape-record the interview and to utilize the data was obtained from each of the participants. Each participant was assured of the confidential and anonymous nature of his or her comments and that a profile of the participant would be in the form of a general biographical description to protect the possibility of identification by association. Participants were also fully informed as to the purpose of the study, the reason for selection as a participant, and how their responses would be reported.

SUMMARY

The intent of chapter 3 was to provide a detailed description of the conceptual framework, the study design, the decisions made, and the measures taken to address the validity, reliability and ethical concerns during the conduct of the study.

The conceptual framework for the study was based on Dunn's (1981) Model of a Policy System which was comprised of policy stakeholders, the policy environment and public policies. The study was designed as a qualitative case study to determine if eliminating the exclusive scope of practice clause from the Nursing Profession Act was a feasible policy solution to the perceived need to eliminate barriers to the provision of professional services, or if other solutions were more desirable and feasible. Following an initial literature and document review to establish that elimination of the exclusive nursing scope of practice was a significant policy issue in Alberta, an interview schedule was established for the participant groups and pilot tested.

Fourteen participants were selected by a process of purposive sampling. Each study participant was selected from one of four stakeholder groups considered to be central to the elimination of the exclusive nursing scope of practice from existing legislation. The four groups were: registered nurses, licensed practical nurses, policy-makers and the public. Seven registered nurse participants and one licensed practical nurse participant were selected on the basis of a) their knowledge of health profession legislation and regulation; and b) their knowledge of the proposed *Health Professions Act*. Three participants representing the Departments of Health, Labour and Advanced Education and Career Planning were included based on the responsibility of these departments for health profession legislation in Alberta. Three participants who were not actively engaged in a profession, but were knowledgeable regarding health profession legislation were selected to represent the public interest.

Data collection was carried out through document analysis prior to and concurrent with the interviews. Semi-structured interviews were conducted with identified participants in three phases: nursing respondents, public respondents and finally the respondents for the Departments of Health, Labour, and Advanced Education and Career Development. Content analysis and comparative analysis procedures were used in analysis of both the document and interview findings and in determining the slight variation in formats for each group of participants. A continuous review of the data collection procedures, development of coding categories, and interpretation and reporting of findings was conducted throughout the study.

The analysis of data was conducted according to an analytical framework consisting of three components. The first component focused on the historical description of the introduction of the exclusive nursing legislation. The second component focused on the desirability and feasibility of eliminating the nursing exclusive scope of practice clause from the Nursing Profession Act. This section included the factors contributing to the proposed change in legislation and the perceptions of stakeholders to the proposed legislation. The third component included the determination of feasible policy alternatives and the development of recommendations for policy development.

The reliability and validity of the study were enhanced through the utilization of methods such as triangulation, external review, and the provision of a detailed descriptions of the context of the study, the stakeholder perspectives, and the research methodologies and decisions. The assurance of confidentiality of interviewees and the provision of formal consent to use the interview data were the major strategies utilized to address the ethical concerns of participant involvement.

CHAPTER 4

THE ALBERTA CONTEXT

Chapter 4 provides a description of the changing policy environment for the regulation of health professions in the Province of Alberta, based on a review of historical documents, government position papers, relevant literature, conversations with professionals and policy-makers and related work experience. The historical development of health professional legislation reviews, final reports and government policy directions evolving during the period between 1970 and 1990 is discussed. Secondly, a description of the exclusive practice legislation, particularly as it related to the registered nurses in Alberta and nursing associations in other Canadian provinces, is provided. Finally, the health profession policy environment and the proposed changes to existing legislation in Alberta in the 1990s is described. The major factors affecting issue resolution and policy developments based on the analysis are outlined in the last section of the chapter.

HISTORICAL PERSPECTIVES

Subsequent to major studies undertaken in the provinces of Ontario and Quebec, the provincial government of Alberta perceived a need to review their legislation in light of the proliferation of professions and their increasing social, political, and economic importance. Although other provincial reviews concluded with specific recommendations, early policy directions in Alberta reflected a series of general principles which new or revised profession-specific legislation were expected to reflect.

Special Legislative Committee on Professions and Occupations

In 1972 the Special Legislative Committee on Professions and Occupations was established with the appointment of eight members representing the Government of Alberta and the opposition party. The final report, completed in 1973, is considered the first formal attempt to review all regulated professional groups in Alberta, and continues to be referenced as the 'Chichak Report,' named after the chairperson, Mrs. Catherine Chichak. Under its terms of reference, the legislative committee was to conduct a review of existing legislation pertaining to professions and occupations and to examine the policies and principles underlying such legislation.

The Alberta review was much less ambitious than its predecessors in other provinces, with the final report of 23 pages, significantly shorter than the three-volume, 984-page report generated by the Ontario Committee on the Healing Arts two years earlier. The report focused on the principles and rationale for professional legislation, excluding specific discussion or recommendations regarding specific professional groups as did other provincial reviews. The impetus for the review centered on a number of concerns which had become apparent to government bureaucrats: the proliferation of professional groups and the number of requests for self-governing authority; a lack of public understanding as to what services specific professions provided, and the process for initiating complaints regarding professional conduct or fee schedules; practices related to training, retraining and other licensing requirements; the lack of uniformity in the administration of legislative acts; and jurisdictional disputes between related professional groups.

In attempting to balance the need to ensure protection of the public interest with the professional benefits of self-regulation, the Committee linked the increasing number of requests for self-regulation to what they perceived as a lack of clearly defined self-regulation criteria and the pursuit of misdirected professional interests. Early into their review, they concluded that self-governance authority should only be granted after careful review and only on the basis of public interest. To substantiate their views, the Committee made direct reference to three of the studies generated in Ontario and Quebec:

> The power of self-government should not be extended beyond the present limitations, unless it is clearly established that the public interest demands it and that the public interest could not be adequately guarded by other means. (Ontario Royal Commission on the Inquiry into Civil Rights, 1968, p. 1209)

> That as a general rule, the pressure created by occupational groups . . . to be given self-regulatory powers ought to be resisted. (Ontario Committee on the Healing Arts, 1970, p. 51)

> That designation be limited to professional bodies after careful consideration, and to delegate the power to regulate, in varying degrees, the conditions of professional practice in the public interest. (Quebec Commission of Inquiry on Health and Social Welfare, 1970, p. 77)

The Committee also drew attention to a relationship between licensing and manpower availability, suggesting that licensing standards could be associated with artificial shortages in the skilled workforce. In further articulating their point, the Committee quoted Milton Friedman's (1962) stern warning that "licensure almost inevitably becomes a tool in the hands of a special producer group to obtain a monopoly position at the expense of the rest of the public" (p. 148).

Although professional jurisdictional disputes and 'turf protection' had been central to other reviews, the Alberta report did not accord these issues similar emphasis. The Committee observed that there was a "certain amount of conflict between parent professional groups and sub-groups . . . [stemming] from a disagreement over who should do certain types of work" (Interim Report, 1973, p. 10). The exclusive right to perform designated tasks was identified as the basis for the conflict, and described as arising from the parent group's attempt to prevent infringement on what was perceived as an exclusive work jurisdiction. The result, according to the Committee, was that the control of one professional group by another "creates unnecessary problems and does little to enhance the public interest" (Report of the Special Committee of the Legislative Assembly of Alberta on Professions and Occupations, 1973, p. 8). In their view, it was desirable to have a spectrum of practitioners including specialists, general practitioners, para-professionals, technicians, assistants and aides, all of whom could advance from entry-level to advanced training programs.

In this first attempt at reviewing professional legislation in Alberta, the mandate was broad and intended to establish, or reaffirm, guiding principles of self-regulation. These principles, in the form of recommendations, formed the framework for future revisions to all professional and occupational legislation (Report of the Special Committee of the Legislative Assembly of Alberta on Professions and Occupations, 1973, pp. 19-22). The resulting twenty-one generally stated recommendations had a familiar ring and, similar to other provincial reports, were not readily adopted. Nevertheless, in retrospect, most of the recommendations have continued to be central to discussions on professional regulation for over 25 years.

One of the proposed recommendations was to subsume all self-governing health professions, or broad groups of related professions and occupations, under umbrella legislation or cluster Acts as a means of administering the projected increase in health profession groups (Report of the Special Committee of the Legislative Assembly of Alberta on Professions and Occupations, 1973, p. 22). Reaction to the concept, particularly from free-standing professions, was swift and negative, contributing to the temporary sidelining of the recommendation. However, 10 years later, umbrella legislation incorporated 15 professional groups under the *Health Disciplines Act* (Health Workforce Rebalancing Committee, 1994, p. 20). Although this Act did not include the traditional professions, all of whom were regulated under free-standing statutes, the concept of a single act for all health professions remained a preferred alternative to existing legislation.

A number of recommendations focused on the use of para-professionals (Report of the Special Committee of the Legislative Assembly of Alberta on Professions and Occupations, 1973, pp. 7-8). The Committee, perhaps naively, hoped that jurisdictional disputes between professional groups "could be kept to a minimum" in the future (p. 9). Anticipating a trend toward team practice, they emphasized that "flexibility in areas of practice will become more important in the future" (p. 7). Although this principle was often reiterated in forthcoming years, the number of exclusive practice jurisdictions increased. In addressing the inevitability of jurisdictional disputes, the Committee made only a general reference to the need for "some specific mechanism to be developed" although they did recommend that no professional group should be controlled by members of another professional group, except for matters of work supervision (p. 9). Although this principle had little immediate impact, the intent was later applied to the historic relationship between registered nurses and licensed practical nurses. In 1983 the licensed practical nurses (at that time called nursing assistants) were included under the Health Disciplines Act. In more recent times, the impact of this principle has also been evident in the shift away from the traditional monopolies accorded physicians and dentists.

Consistent with all other commissions, the Alberta report emphasized the protection of the public interest as being the only legitimate purpose for professional legislation, and that the granting of professional self-governing powers should occur only when "the public interest would be better served if such legislation were passed" (Report of the Special Committee of the Legislative Assembly of Alberta on Professions and Occupations, 1973, p. 19). In this regard, the Committee made reference to compulsory membership in professional associations, "which in some cases may be necessary to ensure that the public is adequately protected" (p. 20). However, specific mention of mandatory registration was omitted from the final list of recommendations. Although this notion was casually mentioned in this Report, it was another of the recommendations which would be returned to at a later date, and become the focus of vigorous debate, particularly for the nursing profession.

The remaining recommendations were vaguely worded proposals similar to those espoused by other Commissions:

> that [new] services are not merely fragmentations or duplications of more comprehensive services of associations already recognized; . . . that standards of conduct be as clearly defined as possible; . . . that professions develop formalized continuing education programs for their members; . . . that professional groups publicize more effectively the complaint procedures available; . . . and that a Council for Professions and Occupations be established to make recommendations to the Minister on all new or amended legislation. (pp. 19-22)

With the exception of the last recommendation, which eventually became a reality for some professional groups, most of these principles produced little evidence of change. The number of designated health professions and exclusive practice jurisdictions steadily increased following the release of the Report and the public has remained relatively unaware of service availability or complaint procedures. Further, it is only recently that professional groups have begun to face the complexity of ensuring the continued competency of its membership.

The impact of the Chichak Report was not evident until many years following its completion. Some of the recommendations are only beginning to be realized more than 20 years later. Nevertheless, the report was the first attempt to review professional legislation issues and served notice that future legislative initiatives would be based on a number of principles, similar in their application to all professions.

Policy Governing Future Legislation for the Professions and Occupations

Subsequent to the report of the legislative committee, a policy paper entitled Policy Governing Future Legislation for the Professions and Occupations was released in 1978. Memories of present civil servants are sketchy in relation to circumstances surrounding the development of this document. Since many of the recommendations were extrapolated from the Chichak Report (1973), it is probable that the policy paper was intended to reaffirm the direction which had been proposed in the Chichak Report (1973), particularly in an era of proliferating professional groups.

The stated intent of the policy paper was that "a systematic approach shall be established for the regulation and the control of standards pertaining to the professions and occupations. The primary reason for such standards and regulations will be to protect the public" (Government of Alberta, 1978). As with other reports, there was a discretionary reference to self-governance, cautioning that authority would be delegated only when it was clear that the public could best be served by the delegation of such authority (p. 1). In keeping with this stated direction, the development of criteria to determine which professions and occupational groups would require legislation was considered a priority.

The tenor of the 12 policy statements depicted an urgency to establish what was described as "uniformity, continuity and consistency in legislation," appealing for the use of common terminology and format, clearly defined fields of practice, publicized public complaint and disciplinary procedures, inclusion in regulations of standards for licensure, and the development of formalized continuing education programs (Government of Alberta, 1978, p. 1). Other recommendations referred to in the Chichak Report, such as a formalized structure to approve educational programs and the need for reciprocity and portability of credentials, were also reiterated in the policy statements. All of these policy directions, some of which were later implemented in the *Health Occupations Act* (1980), have continued to have a presence in current discussions.

Two of the policy statements may have inadvertently compounded, rather than resolved, the problem of increasing requests for legislative recognition and escalating interdisciplinary struggles. The policy stated that "all persons practising a regulated profession or occupation must be licensed . . . and that the field of practice of a professional group seeking legislative recognition must be clearly described" (Government of Alberta, 1978, p. 1). In effect, both of these statements promoted the pursuit, by professional groups, of defined and exclusive practice. Ironically, this was not a direction which the Chichak report had endorsed (Special Committee of the Legislative Assembly of Alberta, 1973, p. 7). It is not clear why this particular recommendation was included given the inherent potential for professional struggles to emerge as a result of exclusive jurisdictions. However, as several of the traditional health professions seized the opportunity to obtain exclusive practice legislation, it had become difficult for government to withhold such approval since the principle had been 'legitimized' in the policy statement (Government of Alberta, 1978, p. 1). Although reluctant to reverse an apparent policy direction, some bureaucrats were predicting that exclusive practice legislation would inevitably precipitate interdisciplinary disputes.

Introduction of Umbrella Legislation

By the 1980s there was a growing need to establish a mechanism to regulate the large numbers of groups seeking designation and to curtail the approval of exclusive scopes of practice (Health Workforce Rebalancing Committee, 1994). Regulatory discussions were reflecting a shift away from the formation of more exclusive jurisdictions to the possibility of right-to-title legislation. Under this form of legislation, a practitioner retained the option of registering with an association, thus assuming the right to refer to themselves as a registered practitioner. This designation was intended to enable the public to determine who was deemed competent by a professional association, much like a 'seal of approval.' The advantage to this form of legislation was that the public could chose to obtain service from a regulated or non-regulated practitioner, and practitioners were permitted voluntary registration with their association depending on whether they wished to benefit from use of a restricted title. In addition, right-to-title legislation, while restricting who could use specific titles, did not perpetuate monopolies created by exclusive practice areas. Table 1 provides a comparison of exclusive scope of practice and protection of title legislation.

In 1981 the *Health Occupations Act* was proclaimed, “to provide a means for regulating a wide variety of health disciplines requesting legislative recognition” (Health Disciplines Board, 1985, p. 1). The intent of this umbrella legislation was to prevent the proliferation of separate pieces of legislation by incorporating, under one Act, all health disciplines who were in the process of seeking designation as a profession. Remaining outside the umbrella legislation were the fourteen free-standing professional groups, eight of which continued to have exclusive scopes of practice. Table 2 depicts Health Professional Legislation in Alberta as it evolved between 1982 and 1993.

Shortly after the proclamation of the Act, a number of limitations prompted amendments which were incorporated as the *Health Disciplines Act*, proclaimed in 1984. The *Health Occupations Act* was renamed the *Health Disciplines Act* in response to concerns that the term ‘occupation’ implied a low status. The regulation-making powers of the Health Disciplines Board were expanded to include educational and registration qualifications, scopes of practice, and standards of conduct. And, in recognition that some of the disciplines were able to assume the duties considered to be the mandate of the Health Disciplines Board, provision was made for the delegation of governance authority to the professional association. One of the earliest groups to be designated under the Health Disciplines Act was the nursing assistants (renamed licensed practical nurses in 1991). Following the approval of regulations, authority to regulate practitioners was transferred to the Professional Council for Registered Nursing Assistants in 1986 (Health Disciplines Board, 1986, p. 11).

Table 1

Comparison of Exclusive Scope and Protection of Title*

	Exclusive Scope	Protection of Title
Purpose	Exclusive scope is intended to prevent individuals, not registered with a particular association, from offering services to the public. Its purpose is to control markets for professional services.	Protection of title is not intended to prevent other types of professionals from practising, but rather to afford a means for the public to distinguish practitioners who have met certain qualifications from those who have not. Its purpose is to provide information.
Scope	Traditionally, exclusive scopes of practice were very broadly defined: (e.g., the diagnosis of illness and treatment of disease).	Protected titles are generally very specific and are in some cases further limited by the adjective *registered*.
Titles	Only registered members are entitled to use the title reserved for these professions.	Only registered practitioners are entitled to use title reserved for these professionals.
Who may Practice	Only individuals authorized by legislation may practice within the exclusive scope (licensed professionals or others with legislative sanction). Practising without being registered is an offence and an individual may be subject to a fine or imprisonment.	Individuals who are not registered may practise within the defined scope of practice.
Consumer Choice	Consumer and employer choice is limited. They may choose between licensed practitioners but they cannot choose between the services of registered and unregistered practitioners.	Consumers and employers may choose to retain the services of a registered practitioner who must have certain qualifications and comply with the standards in legislation, or they may choose a practitioner offering similar services who is not registered.

* Adapted from Alberta Health Workforce Rebalancing Committee, 1994, p. 5.

Table 2

Health Profession Regulation in Alberta**

Free Standing Statutes	
Alberta Health	**Alberta Labour**
Dental Profession Act*	Occupational Therapy Profession Act
Medical Profession Act*	Opticians Act*
Nursing Profession Act*	Pharmaceutical Association Act*
Optometry Profession Act*	Podiatry Act
Physical Therapy Profession Act	Psychology Profession Act
Registered Dieticians Act	Social Workers Act
	Chiropractic Profession Act*
	Dental Mechanics Act*

Umbrella Statutes (Alberta Labour)	
Health Disciplines	**Dental Disciplines**
Acupuncturists	Dental Assistants
Combined Laboratory & X-ray Technicians	Dental Hygienists
Electroencephalographers	Dental Technicians
Emergency Medical Technicians	
Licensed Practical Nurses	
Medical Laboratory Technologists	
Medical Radiation Technologists	
Mental Deficiency Nurses	
Midwives	
Psychiatric Nurses	
Respiratory Therapists	

* Legislation provides for an exclusive scope of practice

** Adapted from Alberta Health Workforce Rebalancing Committee, 1994, p. 3.

The most significant feature of the *Health Disciplines Act* was the protection it provided to practitioners of the designated disciplines. The provisions of the Act gave individuals the right to use titles reserved for them provided they were registered with their discipline. That is, only those who were registered with the related association could refer to themselves as respiratory therapists, nursing assistants or medical radiation technologists, for example. The advantage to this means of recognition allowed unregistered practitioners to provide a service, provided they did not refer to themselves by a restricted title. The disadvantage was that the certification process essentially amounted to quasi-licensing since although a practitioner was eligible to practice, those who were not registered were less likely to be hired. As was pointed out by the Special Legislative Committee, "By default, we have linked certification and licensing" (Interim Report, 1973, p. 8). Although neither the legislative committee nor the later policy statement clarified this perennial issue, certification was seen by policy-makers as a regulatory mechanism which provided the public with competent practitioners, yet preserved the right of the public to select the practitioner of his/her choice.

The second and more important advantage of the *Health Disciplines Act* was the protection it provided in relation to contravention of other legislation. Although the *Health Disciplines Act* did not give practitioners an exclusive scope of practice, the services registered practitioners could provide were specified in regulation. In this way any registered practitioner who was providing a service considered within the exclusive scope of another professional group was exempted from that exclusive legislation. The importance of the exemption to disciplines included under this umbrella legislation became evident as more free-standing professions were granted exclusive practice rights. One of the examples related to licensed practical nurses. Once included under the *Health Disciplines Act*, this group was exempted from the *Nursing Profession Act* and thus permitted to administer oral medications, an activity which had, traditionally, been a part of the exclusive practice area for registered nurses. This apparent contradiction in the common understanding of exclusive practice areas related to an observation made by Boase (1994), wherein she noted that the authority behind practice areas was often not situated in the discipline's legislation, but rather in references to their discipline in the legislation of other groups.

Despite the intent of the Health Disciplines Act, the number of groups seeking legislative recognition continued unabated. In 1983 the first five groups to be designated were respiratory technology, nursing assistants, rehabilitation practitioners, acupuncturists and hearing aid practitioners. By 1985, three more groups had been added: emergency medical technicians, medical radiation technologists, and combined laboratory and x-ray technicians (Health Disciplines Board, 1984; 1985). Ten years later, the number had almost doubled, with several more groups having been designated as a regulated profession.

Not all groups were successful in their quest for recognition. More than half of those seeking designation were denied on the basis that the field of practice did not incur significant risk to the public. Many of these undesignated groups were little known or peripheral to the health field: domiciliary midwives, electrologists, herbalists, orthomolecular consultants, orthopedic technologists, remedial gymnasts, homeopathic practitioners, health record technicians, chiropodists, athletic therapists, electroneurophysiological technologists, and dietary technologists (Health Disciplines Board, 1994/1995, p. 31).

The 11 groups currently regulated under the *Health Disciplines Act* have been designated on the basis of specific criteria: the risk to the public, the nature of services provided, the degree of supervision, complexity of the task, and availability of educational programs (Health Disciplines Board, 1984). It is noteworthy that all of the groups governed under the umbrella legislation are supportive of this regulatory model, noting the uniformity of common administrative functions, fairness for all the disciplines, and the relatively 'user-friendly' nature of the legislation. In their view, this was a legislation model which could apply to all health professions (Health Workforce Rebalancing Committee, 1995, p. 11).

THE EMERGENCE OF EXCLUSIVE PRACTICE LEGISLATION

The 1980s were a time of significant legislative activity. In addition to groups of non-regulated practitioners who were seeking designation under the *Health Disciplines Act*, several of the traditional health professions were lobbying for exclusive scope of practice legislation. The pressure for this provision could be easily traced back to the recommendation in the Policy Governing Future Legislation for the Professions and Occupations (1978) stipulating that professionals should be licensed. Traditionally, this type of legislation, along with mandatory registration, provided a broadly defined scope of practice from which others were legally excluded. The most obvious advantage of such legislation was the professional status accorded the profession by means of the legal right to exclude unlicensed practitioners from a restricted jurisdiction. This form of legislation also was thought to enhance professional job security, although this perception later proved to be false. From a government perspective, and one which has been highlighted repeatedly in various provincial reports, licensing professionals had the potential for developing monopolies, and was recommended with caution, only when no other means of regulation was appropriate (McRuer Commission, 1968; Committee on the Healing Arts, 1970; Castonguay Commission, 1970; Health Professions Legislation Review Committee, 1989; Law Reform Commission, 1994).

Approval of Exclusive Nursing Practice Legislation

Despite apparent limitations associated with exclusive legislation, an exclusive practice clause and mandatory registration were included in the newly revised *Nursing*

Profession Act in 1983. This landmark legislation, representing the culmination of several years of intense lobbying, was the first legislation in Canada to provide the nursing profession with a license to practice and one which other provincial nursing associations attempted to duplicate. For those critics who puzzled over the apparent contravention of official government policy, the explanation was to be found in the politics of policy development. As Boase (1994) explained it, "Strange things happen when a strong lobby is mounted on the minister responsible" (p. 81). The nursing association was very aware of the significance of a defined scope of practice with an exclusive license to practice. At the time, a lawyer specializing in health discipline legislation was hired to guide the process through the legislative hurdles. Although this was common practice for other professions, as one official had commented, "Health care law has become a popular and lucrative specialty forcing the legislation over the doubts of civil servants" (Boase, p. 97).

In addition to expert legal advice, the nursing profession, as the largest health group, represented approximately 20,000 potential votes. Sophisticated in lobbying strategies, the Association had a good grasp of the salient issues of professional advancement. It was also opportune that the Conservative party whip at the time was a prominent nurse and provided informal guidance as the bill moved through the legislature.

Many public servants in Alberta were concerned about the exclusive nursing legislation and warned against its passage. Several suggested there had been insufficient exploration of the implications and that resulting jurisdictional disputes would lead to legal actions. Although all the disciplines designated under the *Health Disciplines Act* were exempted from the nursing legislation, it was thought that auxiliary personnel working in nursing homes and seniors lodges, as well as psychiatric nurses (who later became a regulated discipline) and homemakers could be carrying out functions in contravention of the proposed changes to the nursing legislation. Predictably, the medical profession was also opposed to the legislation on the basis that the defined nursing scope of practice violated the medical domain. Resolution of this particular issue was achieved by acceptance of the physician recommendation that the scope of practice statement be changed from the "application of knowledge" to read "the application of nursing knowledge" (Nursing Profession Act, 1983, Sec., f).

The concerns about exclusive practice resulted in the addition of a clause in the Act giving discretionary powers to the Minister. While section 3(1) established mandatory registration, section 4 provided an exemption: "After the Minister has consulted with the council of the Association, the Lieutenant Governor in Council may exempt a person or class of persons from the application of section 3(1)." In essence, this exemption diluted the licensing and scope of practice sections, in an attempt to modify the potential licensing difficulties. However, the passage of the Nursing Profession Act in 1983 was perceived to be an impressive interest group victory. As one official described the process, "Everyone got what they wanted" (Boase, 1994, p. 68). The nursing profession had been given the prestige of a statute that granted a license, a defined scope of practice, and mandatory registration. And the discretionary power retained by government prevented the exclusion of others from performing what appeared to be nursing functions.

Issues Arising From Exclusive Nursing Legislation

Shortly after the passage of the *Nursing Profession Act*, a number of issues arose which focused on the administration of medications as an exclusive nursing activity. Teachers and daycare workers were giving medications to children at the request of parents, and homemakers were administering medications to persons in their home, usually family members. There were also a number of complaints from administrators of extended care facilities who, for some time, had allowed nursing aides or licensed practical nurses to give oral medications to patients at the request of the nurse in charge. With the designation of the licensed practical nurses under the *Health Disciplines Act* in 1983, this issue was resolved, at least legally. However, although any health group governed under other legislation was exempt from the exclusive nursing jurisdiction, the issue of administering medications remained an irritant to other groups and to government, and was eventually removed from the Nursing Profession Act in 1991. With this deletion, exclusive nursing practice was then defined as "the application of professional nursing knowledge for compensation for the purpose of i) caring for physically or mentally ill persons; and ii) caring for and assessing the health of well persons" [*Nursing Profession Act*, 1991, I (f)].

Issues Surrounding the Definition of a Nursing Scope of Practice

Inherent to exclusive practice legislation was a description of those functions considered exclusive to the profession. Of all health professions, the nursing profession has had perhaps the most difficulty in establishing a concise, specific description of what nurses do and what distinguishes nurses from other health professionals. It has been this difficulty which has led to a broadly defined exclusive scope of practice. The 'pursuit of definition' has been a life-long preoccupation by more than one nursing leader or academic since, by its very nature, nursing is a broad and often non-specific discipline. Thus, while the exclusive practice statement reflects the breadth of the discipline, it would be difficult to think of any health care activity, performed by any health professional, which would be outside of this definition. That is, most health professionals would provide care to a physically or mentally ill person and assess the health of well persons, albeit it from a particular professional perspective. If a full legal interpretation were applied to the exclusive practice clause in nursing, the provision of service by any other professional or health related group would be limited significantly. This was never the intention of the nursing association. As evidence of this intent, the AARN has never legally challenged the intrusion of any other health group. What was important to the Association in seeking legislative changes in 1983 was that the profession received recognition similar to other free-standing professions with exclusive jurisdictions, and, that all members practising nursing were required to register with the Association. The intent of this pursuit was always on the basis of protecting the public interest.

Release of Policy Paper

Following almost a decade of legislative activity which focused on the designation of groups under the *Health Disciplines Act*, another policy paper, Principles and Policies Governing Professional Legislation in Alberta, was released in 1990. Like other policy papers, this one reiterated many of the principles evident in the Chichak Report (1970). The central theme reflected an appeal for a balance between several potentially conflicting objectives of protecting the public from incompetent providers, yet promoting cost effectiveness in the provision of professional services.

Under a section entitled "Scope of Practice and Right to Title" there were two points which had not appeared in any previous policy statements. Reference was made to the apparent overlapping functions amongst professionals, and to the desirability of having all practitioners able to provide services appropriate to their training and competence. To the casual reader, these principles were obvious. However, despite their simplicity, they could have been instrumental to the policy direction which the government adopted four years later. In fact, it could be interpreted that these principles were the primary rationale for the eventual elimination of exclusive practice clauses from all health profession legislation. Civil servants have various interpretations as to whether the release of the 1990 policy statement was actually a veiled attempt at redefining the policy direction. However, the argument could be made that health legislative reviews in other provinces had based significant regulatory changes on similar principles and that their subsequent policy direction would not have gone unnoticed in Alberta.

Despite several policy papers and the introduction of umbrella legislation, the prevailing system of professional legislation remained complex and difficult to reform.

Amendments to existing statutes required a time-consuming profession-by-profession approach, and inconsistent and overlapping professional practices remained. By late 1992, on the eve of a provincial election, several factors related to professional legislation were evident. Professional legislation remained cumbersome and complex. Fifteen health professions, each with separate statutes, eight of which contained exclusive scope of practice clauses, and fifteen professional groups under umbrella legislation continued to exist in Alberta. Despite policy statements, little was evident to suggest a reduction in barriers between professional groups. Other Canadian provinces had already implemented changes in professional legislation and could (and did) provide a model for future changes in Alberta. The rising cost of health care was a continuing concern, in part, attributed to by inefficient utilization of manpower resources. Government regulation of any type was becoming the focus of attention.

PROPOSED CHANGES TO HEALTH PROFESSION LEGISLATION IN ALBERTA

In 1993 the newly elected Government of Alberta held a series of Roundtables on Health throughout the province. Arising from these forums were two concerns related to health manpower: (a) the health system must encourage the use of appropriate services provided at the least cost by a range of qualified providers; and (b) the health system must be consumer driven, based on community priorities and delivered cooperatively by health providers and community organizations (Alberta Health Workforce Rebalancing Committee, 1995, p. 1). In addressing these issues, the Ministers of Labour and Health established the Alberta Health Workforce Rebalancing Committee with the mandate to "propose a method of regulating health service providers and to recommend alternate approaches to workforce utilization" (p. 1). Unlike other provincial reviews which had been conducted at arms-length from government, this committee was comprised of seven MLAs, five public members and three ex-officio public servants.

New Directions for Legislation Regulating the Health Professions in Alberta

The first of three documents released by the committee was a discussion paper, entitled **"New Directions for Legislation Regulating the Health Professions in Alberta"** (1994), which was based on post-election public discussions on health care, previous policy statements, and directions in regulatory policy which were evident in Quebec and Ontario. The intent of the document was to stimulate discussion concerning a model for change to the existing regulatory structure outlined in the paper. The details of the proposed changes are discussed in a later section. In brief, the Committee proposed umbrella legislation for all health professions under a *Health Professions Act*. The intent was to provide a common regulatory framework for the twenty-nine health professions, replacing sixteen existing health profession statutes with one omnibus act. The proposed legislation eliminated all exclusive scopes of practice, replacing this form of regulation with right-to-title regulation, mandatory registration, and a list of restricted activities which could only be performed by regulated practitioners (Health Workforce Rebalancing committee, 1994).

The release of the draft document was followed by a series of 10 public meetings held throughout the province. Approximately 3,500 people responded, representing health care providers, employers, labour unions, professional associations, training institutions, regional health authorities, the business community and members of the public. Subsequent to the public forums, the Committee met with 76 groups for a more detailed discussion of the proposed changes (Alberta Health Workforce Rebalancing Committee, 1995, p. 3). Most of the issues discussed by presenters focused on several themes: maintaining public protection, particularly the potential impact of unregulated practitioners; ensuring that regulatory functions were in the interest of the public; improving public accountability of regulatory bodies; encouraging interprofessional collaboration in providing appropriate care and services; enhancing consumer choice and information; and removing barriers preventing professionals from practising to their full competency. Although there were philosophical differences on how best to manage these issues, there was agreement that existing professional legislation did not meet the needs of the current health system (Alberta Health Workforce Rebalancing committee, 1995, p. 2).

Discussion Paper II: A Report of the Health Workforce Rebalancing Committee

The responses to the New Directions discussion paper were synthesized in a second document, **"Discussion Paper II,"** released in 1995 (Alberta Health Workforce Rebalancing Committee, 1995, p. 7). Issues were categorized by topic area including: public protection, barriers to practice, governance, public accountability, interprofessional collaboration, consumer choice and consumer information. However, as the Committee pointed out, capturing the essence of these recurring themes was challenging because of contradictory viewpoints.

Exclusive scope of practice was a theme which stimulated polarized discussion and revealed the diversity of interests amongst participants. Some believed that exclusive scopes of practice were not necessary, did not exist in practice, and promoted inappropriate hierarchies and interdisciplinary disputes. Others supported the retention of exclusive scopes of practice as the only means to protect the public from incompetent practitioners. The primary concern of health care workers was the competency of practitioners rather than the perpetuation of discipline-specific tasks. This view was also consistent with the belief that practitioners from several professions could be competent to provide the same services. Thus, the consensus seemed to be that exclusive scopes of practice should be replaced with defined scopes of practice which would allow for greater recognition of overlapping skills (Alberta Health Workforce Rebalancing Committee, 1995, p. 9). However, participants were not in favour of eliminating the mandatory licensing requirements commensurate with exclusive practice areas. The alternative, right-to-title legislation was seen as ineffective, since professional associations would have no jurisdiction over unregistered individuals (p. 10).

One of the most significant recommendations in the New Directions document was the replacement of exclusive practice jurisdictions with a list of restricted activities which only designated professionals could perform. The Committee was unable to discern a consensus on the proposed listing of certain acts as 'dangerous' and the provision that the acts be performed only by a designated professional. Some felt that any act was potentially dangerous, depending upon the circumstances in which it occurred. Others felt a list of acts could be supported provided professional associations were consulted, the list was more extensive than the one proposed in the discussion paper and the term 'dangerous' was replaced with 'controlled or licensed acts' (pp. 10-11). Most participants, particularly professionals, were aware of similar legislation in Ontario. With this knowledge, there were also a variety of assessments of the relative merits of the proposal. In the end, this recommendation was retained in principle and expanded, considerably, from the original discussion paper.

Several of the professional associations and individual practitioners identified barriers in existing legislation (usually in reference to exclusive scopes of practice) which prevented them from providing services they felt they were competent to provide. This complaint was also related to restrictions on referrals, necessitating having a patient seen by yet another professional, such as a general practitioner, who then could make the necessary referral. Many of the groups with exclusive practice jurisdictions felt they were competent to order diagnostic tests, prescribe drugs, and admit patients to hospital without having to refer patients to a physician. Although these have been long standing and contentious issues with a number of groups, some of the participants viewed this expanded authority as increasing health care costs, increasing overlap and duplication of functions and possibly lowering the quality of care (p. 19). Nevertheless, the conclusion of participants seemed to be that unnecessary limitations on who could provide services imposed unnecessary costs and limited consumer choice.

Closely aligned with perceived barriers in legislation was the method of reimbursement. Many participants felt that the fee-for-service payment system promoted inappropriate utilization and unnecessary provision of services, particularly in relation to exclusive professions. This concern was particularly evident when similar services were insured at different rates, depending on the provider. The argument was that the public was likely to choose an insured provider when, in fact, an uninsured provider may, in some instances, be able to provide appropriate, competent service, at less cost (p. 21).

Following the release of the Discussion Paper II, the Committee received 50 written responses which, for the most part, duplicated previous discussions. In preparation for the final report, the Committee invited approximately 100 representatives from a broad range of stakeholder groups, e.g., professional regulatory bodies, regional health authorities, unions, employer organizations and consumer advocacy groups to participate in a concluding discussion of outstanding issues. In the summation of viewpoints, the Committee concluded that there was "general support for the directions recommended in Discussion Paper II" (p. 2).

Release of the Final Report of the Health Workforce Rebalancing Committee

The final report of the Alberta Health Workforce Rebalancing Committee was released in late 1995. The report, entitled **"Principles and Recommendations for the Regulation of Health Professionals in Alberta,"** contained the five principles, thirteen recommendations and three observations much as they had appeared in Discussion Paper II. In essence, the Report outlined the framework for the proposed Health Professions Act which was premised on the five guiding principles: the public must be protected from incompetent or unethical health professionals, the health professional regulatory system should provide flexibility in the scope and roles of professional practice so the health system operated with maximum effectiveness, the health professional regulatory system should be transparent to the public, the regulatory process for health professions must be demonstrably fair in its application, and the regulatory system must support the efficient and effective delivery of health services (Alberta Health Workforce Rebalancing Committee, 1995, p. 2). These often-repeated principles seemed, on first inspection to be blatantly obvious, if not simplistic. However, from a more thoughtful perspective, they were, for perhaps the first time, to have significant influence on the drafting of the new legislation and subsequent stakeholder discussions.

A PROPOSED MODEL FOR HEALTH PROFESSION LEGISLATION IN ALBERTA

The proposed legislation regulated 31 groups under one *Health Professions Act*, replacing 15 separate statutes. From the public's perspective, this omnibus legislation was intended to provide greater uniformity in the regulatory processes, increased accountability and more clearly defined avenues for complaint resolution. Administratively, a single Act was seen to be more efficient, potentially more cost-effective and easier to administer, with more flexibility to address cross-professional issues such as overlapping scopes and interdisciplinary practice (Alberta Hansard, April 28, 1998, pp. 1779-1780). Also, the trend towards consistent, single-statute legislation for all health professions was evident in other provinces.

From the point at which health profession legislation came under review in 1994, the main objective, according to Rob Renner, MLA and Chair of the Health Professions Act Implementation Steering Committee and the Advisory Committee on Restricted

Activities, was to "reduce barriers to interdisciplinary practice and improve choice and access to the health practitioners for consumers, employers, and communities" (Alberta Hansard, April 28, 1998, p. 1780). Although there was very little opposition to this basic objective by the professional groups, not all of the professions were in favour of a single statute. The nursing profession was one group who believed their existing legislation worked well and supported retention of their own act. However, in discussions with all of the stakeholders, the Alberta Workforce Rebalancing Committee (1995) reported general acceptance of a single statute, provided that profession-specific matters were properly addressed (p. 11). This support was particularly evident from disciplines who were currently governed under omnibus legislation (p. 11).

Framework for the Proposed Legislation

The changes which were proposed within the new legislation in relation to the regulation of professional practice were largely in response to perceived inadequacies in both exclusive scopes of practice and right-to-title legislation. Exclusive scope of practice legislation was intended to ensure public safety by limiting who was authorized to provide a broad range of services. As increasing numbers of professional groups sought this form of regulation, several limitations became apparent. It did not recognize legitimate overlap in the services of related professional groups. In addition, it fostered hierarchical structures, promoted turf protection, and deterred teamwork and collaboration between related disciplines. In reality, the restrictions on practice were often not enforced because they did not reflect the needs in the workplace or the efficient use of qualified practitioners. In brief, exclusive legislation had came to be viewed as a regulatory structure which exceeded what was needed for protection of the public and generated more issues than it solved (Alberta Health Workforce Rebalancing Committee, 1995, p. 24).

Conversely, right-to-title legislation provided less than adequate public protection. Practitioners governed under this form of legislation were not required to register with their respective associations but could provide the same services as registered members. Thus, unless consumers knew which professions were regulated and which titles were reserved, they had little means of distinguishing regulated from nonregulated service providers (p. 24).

The proposed model was intended to resolve the limitations of both exclusive scope of practice and right-to-title regulation through proposed changes to four major components described in the following sections: mandatory registration, right-to-title, controlled acts and defined scopes of practice. The basic features of this model were outlined and compared to current legislation in Table 1 (p. 106). The model also proposed changes to professional self-governance, the structure of professional legislation, and professional accountability. Although these components are important in the proposed legislation, they are not described further because they are peripheral to the research focus of this study.

Mandatory Registration

In existing legislation, registration with a professional association is mandatory for only those groups who have exclusive scope of practice clauses in their professional acts. Under the proposed model, registration of all health care professionals governed under the Health Professions Act will be mandatory. Therefore, "practitioners who are qualified by virtue of their education, are practising substantively within the scope of practice for that profession, and are providing health services directly to patients, must register with their professional association" (Alberta Health Workforce Rebalancing Committee, 1995, p. 27). Although this requirement was supported in principle by most professionals, there were two concerns. The first concern related to the mandatory registration of teachers, researchers and administrators within a specific discipline. These groups, which are generally small in number, were initially excluded from mandatory registration on the basis that they did not provide direct patient care. This recommendation was unacceptable to the registered nurses and others, who lobbied successfully for the inclusion of these groups under the mandatory requirement (*President's Message,* 1998, p. 2). The presentation made by Mr. Rob Renner, MLA, Medicine Hat, in the legislature, in support of Bill 45, Health Professions Act, indicated that "[mandatory registration] applies to the provision of health services, the teaching of the profession to students and practising members, and the supervision of personnel who provide professional services to the public" (Alberta Hansard, 1998, p. 1779). This was a 'last-minute' revision to the Bill which, according to a former Deputy Minister, may return to haunt the stakeholders. Conversely, it may be an example of a concession designed to expedite tabling of the Bill which will inevitably be unenforceable.

A second concern of some professional groups was that mandatory registration did not preclude employers hiring nonregistered and usually less costly practitioners, provided these individuals did not perform controlled acts (which are discussed below), did not use reserved titles, and were not qualified by virtue of their education to register with an association. Although this concern has been regularly expressed in relation to the use of nursing attendants, laboratory assistants and other entry level practitioners, there is little evidence of the extent to which this has occurred in the past, or whether it would escalate under the new Health Professions Act. However, if unregulated practitioners are hired to provide direct care services, competence would continue to be the responsibility of the employer.

Controlled Acts

There was broad support for the notion that practitioners and the public share the risks associated with the provision of many health services, such as prescribing drugs, performing surgery or taking x-rays, and that these services should only be performed by qualified individuals. Under existing legislation, exclusive scope of practice clauses were broad enough to prevent high-risk services from being carried out by unqualified practitioners. Under the proposed changes, all exclusive scopes of practice clauses would be eliminated. Replacing these clauses was a provision for the identification of 'controlled acts' (later referred to as 'restricted activities') which could be performed only by designated professionals, authorized to do so in legislation (Alberta Health Workforce Rebalancing Committee, 1995, p. 8). Although some professionals felt that all acts were potentially dangerous, the intent was to identify those activities which (a) had a high potential for significant, negative consequences to an individual's physical or psychological health, and (b) required a high degree of practitioner judgement, knowledge and skill in performing these activities (Advisory Committee on Restricted Activities, 1997, p. 2). Following lengthy discussion between the professions and government, there was support for the principle of controlled activities as recommended in the final report. However, the task of identifying which acts would be controlled and the terms and conditions applying to the performance of a restricted activity by a professional was to be delegated to a steering group working in collaboration with professionals, employers and consumers.

Right-to-Title

Under existing legislation, all disciplines have right-to title provisions which would remain unchanged and is intended to assist the public to make informed choices. However, criticism has been levied at instances of inconsistent, obscure or misleading professional designations. In the new legislation, it has been proposed that professional titles follow a consistent format (Alberta Health Workforce Rebalancing Committee, 1995, p. 7). In a clinical environment this would mean that, with the exception of those professions who traditionally refer to practitioners as "doctor," all other practitioners would be able to use this title only if they had received an earned doctorate from an approved university, within the profession. While there was broad support for the intent of this proposed change, there have been concerns voiced by many disciplines, and the nursing profession in particular. Until recently, the majority of doctorally prepared nurses have graduated from a variety of non-nursing programs. Although this proposed change in the use of restricted titles does not apply to social or academic settings, the clinical restriction will be contentious for those doctorally prepared nurses, albeit a small number, who are engaged in specialized clinical practice but do not have a doctorate degree in nursing.

Defined Scope of Practice

The defined scopes of practice contained within existing legislation were, particularly for the traditional professions, intended to define an exclusive jurisdiction. Over time, these broadly defined and overlapping exclusive scopes of practice, have "encouraged unproductive competition over turf rather than collaboration between different types of health profession" (Alberta Health Workforce Rebalancing Committee, 1994, p. 11). In the proposed legislation, a defined scope of practice is intended to outline the services provided by members of a profession. It would not restrict practitioners to the provision of specific services nor would it limit the rights of other practitioners to provide similar services (Alberta Health Workforce Rebalancing Committee, 1995, p. 33).

Implementation of Final Report

Immediately following the approval of the Final Report of the Workforce Rebalancing Committee in 1995, the Ministers of Health and Labour jointly appointed the Health Professions Act Implementation Steering Committee to oversee the development of legislative proposals for the new *Health Professions Act*. Separate projects were instituted to identify restricted activities, followed by development of scopes of practice for each of the health professions.

Formulation of Restricted Activities

The Advisory Committee on Restricted Activities was established in early 1996, with the mandate to develop a list of restricted activities and determine which professionals should be authorized to provide these activities (Health Professions Act Implementation Steering Committee, 1997, p. 2). This was a significant part of the proposed legislation changes and, predictably, unfolded as a complex task requiring more discussion than had been anticipated. What was originally intended to be a four month project extended to an eighteen month consultative process with professional regulatory bodies, unions, provincial health authorities, employers, educational institutions, consumer organizations, other government departments, other provincial jurisdictions, and members of the public who had expressed an interest. These consultations were in addition to several expert working groups established to resolve definitional issues related to such areas as invasive procedures, the use of energy, psychotherapy, and diagnosis.

By the Fall of 1997, a list of nine restricted activities (in contrast to thirteen in Ontario) had been agreed to by stakeholders; however, there was disagreement with the proposed placement of restricted activities in the Act. During the process, the mandate of the Implementation Steering Committee had also changed and the determination of which professionals were competent to perform restricted activities became the mandate of the upcoming project, that of developing scopes of practice for each profession (Health Professions Act Implementation Steering Committee, 1997, p. 41).

The formulation of restricted activities was a unique feature of the proposed legislation in Alberta, and one which deviated markedly from any previously contemplated provincial policy revision (Advisory Committee on Restricted Activities, 1997). The only precedent for similar legislation in Canada has been in Ontario, although bureaucrats there do not consider the process complete (Bohnen, 1994). While the principles behind restricted activities seem to 'make sense,' the outcome of this policy direction will not be immediately evident in either Ontario or Alberta. On the immediate horizon there are discrepancies in what has been identified as restricted activities in each province. Alberta has chosen to restrict 'psychosocial interventions' despite significant definitional problems. Ontario, encountering similar difficulties, chose not to restrict this activity. Alternatively, 'diagnosis' is restricted in Ontario but not in Alberta. And 'prescribing a hearing aid' and 'testing for allergies' are restricted in Ontario and not in Alberta. Although the rationale for policy direction has been made public in each province, these provincial differences are difficult to justify on the basis of potential harm to the public.

Scope of Practice Statements

The development of scopes of practice statements for each of the health groups began after the completion of the list of restricted activities, and included development of a description of entry-level practice for each of the twenty-nine groups (Junk & Reid, 1998). The original intent was to include in the scope of practice those restricted activities which members of a profession would be authorized to perform. This framework proved to be not only time-consuming and controversial, but was also vigorously opposed by several professional groups (p. 8). The outcome was that restricted activities were omitted from all scope of practice statements. Issues surrounding how and where restricted activities will be placed in legislation remain unresolved at this time.

With the adjustment in the original objective, there are several issues which remain unresolved in relation to restricted activities and have significance for the prolongation of the legislative process: identification of restricted activities a professional group should be authorized to perform, approval of restricted activities which represent an expansion to a current scope of practice, and a collaborative process to determine common standards of performance. These tasks are encumbered by disagreements amongst stakeholders as to the locus of decision-making, particularly in relation to common standards of practice of overlapping functions. Some stakeholders favour extensive description of restricted activities in regulations. Others prefer that the professional associations determine which activities some or all of their members are competent to perform, and assume responsibility along with the practitioner, for continued competency. Because some of the restricted activities which some professions wish to assume could increase health care costs, a consultative process beyond the professional association will be required. These discussions will be lengthy and convoluted. As stakeholders in Ontario discovered, the completion of the Health Professions Act and regulations could consume several more years of consultation in Alberta.

Bill 45, Health Professions Act

The *Health Professions Act* received second reading April 28, 1998 before the Alberta legislature. Bill 45, a 214-page document, is not expected back in the legislature for third and final reading until the spring of 1999. During the interim, discussions will continue with the professions and other stakeholders to resolve issues which remained outstanding. From a policy perspective, this extension may precipitate renewed discussion on areas thought to be resolved. In the end, if the timelines are adhered to as projected (which are likely because of an approaching election year), the passage of the Act will have consumed six years of discussion and debate, a relatively 'short' time in light of the nearly ten year process which occurred in Ontario. However, in policy terms, the completion of the Act only triggers another perhaps equally strenuous task of developing regulations with each of the 30 professions. Although some of this work has begun, the process will entail lengthy discussion with stakeholder groups. It is also noteworthy that this process continues in Ontario seven years after the implementation of the *Regulated Health Profession Act*.

CHAPTER SUMMARY

The first formal review of professional regulation in Alberta began in 1972 with the release of the Chichak Report in 1973. Prompted by the increasing number of new health professional groups seeking regulation, the report was a compilation of twenty-one recommendations intended to form the framework for future professional legislation. Although the impact of the report was not immediately evident, many of the recommendations have remained central to changes in health profession regulation for decades.

One of the significant recommendations was the proposal that all professional groups be subsumed under umbrella legislation to provide a consistent and coordinated approach to the regulatory process. Although this structure was opposed by the traditional professions, the recommendation was implemented 10 years later in the form of the *Health Disciplines Act*, and 20 years later in the proposed *Health Profession Act*. There was no specific reference to exclusive scopes of practice. However, there was a cautionary recommendation that scopes of practice should be flexible to decrease the propensity to restrictive professional jurisdictions. The recommendation that no professional group should be controlled by members of a parent group was later to have significance for the registered nurses in relation to the subordinate role of licensed practical nurses.

In the decade that followed the Chichak Report, unregulated groups continued to press government bureaucrats for legislative recognition. Five years later, a policy paper entitled **"Policy Governing Future Legislation for the Professions and Occupations"** was released containing an appeal for uniformity and consistency in legislation and reiterating principles outlined in the Chichak Report. However, the reference in the later report to professional licensure seemed inadvertently to have escalated the pursuit of exclusive scopes of practice by the registered nurses and others and was the very direction that the Chichak Report had cautioned against.

In 1981 the *Health Occupations Act,* later renamed the *Health Disciplines Act,* was passed as a partial implementation of the direction outlined in the 1978 policy report. Included under the Act were all of the groups in the process of seeking legislative designation. For the disciplines governed under the *Health Disciplines Act,* the most significant feature of this umbrella legislation was the exemption from exclusive practice legislation in other statutes. All of the traditional professions remained outside of the umbrella legislation, retaining individual statutes, most with exclusive scopes of practice.

The 1980s were a decade marked by a steady increase in number of professional groups included under the *Health Disciplines Act,* and the pursuit of exclusive scopes of practice by the traditional professions. Despite a cautionary reference to exclusive practice legislation evident in most provincial regulatory reviews, vigorous lobbying culminated in the inclusion of an exclusive practice clause and mandatory registration in the Nursing Profession Act in 1983. Restriction surrounding the administration of medications eventually became a thorny issue, and was later removed from the legislation. With this deletion, the exclusive scope of practice continued to reflect the breadth of the profession, but did little to differentiate nursing practice from other disciplines. In fact, restricting the practice of other disciplines, with the exception of the licensed practical nurses, was never the stated intent of the registered nurses. What had become important was the symbolic achievement of professional status similar to other free-standing professions.

Despite another policy paper released in 1990, and the earlier introduction of umbrella legislation, professional legislation, particularly pertaining to the traditional professions, remained complex, inconsistent, with no apparent resolution to disputes generated by overlapping jurisdictions. Thus, in 1994, a newly elected government established the Health Workforce Rebalancing Committee to review existing health profession legislation. After four years of discussion, a single statute, the Health Professions Act, was proposed to regulate all health professions. Unique to the Act was the elimination of exclusive scopes of practice from all professions, and the introduction of restricted activities. These proposed changes were similar to those which had occurred in Ontario, all of which were directed primarily at removing barriers to interdisciplinary practice.

The third and final reading of Bill 45 (Health Professions Act) is anticipated in the spring, 1999. Not all professions are supportive of omnibus legislation. The nursing profession is one of the groups which has voiced opposition, preferring to retain their existing legislation with provision for exclusive practice. While it appears probable that the Health Professions Act will be proclaimed, further discussions to refine proposed changes are anticipated over the next year.

CHAPTER 5

PERSPECTIVES OF THE SELECTED NURSING RESPONDENTS

This chapter provides a detailed description of the responses to interviews conducted with seven registered nurses and one licensed practical nurse. The first section of this chapter provides a description of the responses to the interviews conducted with registered nurses. The second section of the chapter provides the response of a representative of the Professional Council of Licensed Practical Nurses.

PERCEPTIONS OF REGISTERED NURSE STAKEHOLDERS

This section is based on the responses to interviews conducted between May 1 and June 30, 1997 with representatives of the Alberta Association of Registered Nurses, the Staff Nurses Association, a nursing union, an educational facility, and an acute care facility. Interview data obtained from nurse participants are reported in relation to the main data categories and the research questions: the history of the introduction of exclusive nursing scope of practice legislation, perceptions of the desirability and feasibility of eliminating the nursing exclusive scope of practice, and alternate models for removing barriers to practice between health professions. In order to maintain the confidentiality of respondents, registered nurse participants will be referred to as nurse participants (NP).

THE HISTORY OF THE NURSING EXCLUSIVE SCOPE OF PRACTICE

All respondents reported that the exclusive practice clause in the *Nursing Practice Act* was a very important development in the professionalization of nursing as a discipline. The perceived need for and the eventual inclusion of the exclusive practice clause in nursing legislation came to fruition over a number of years. The factors seen as instrumental to the emergence of exclusive practice legislation, how this legislation has been interpreted to other health disciplines and the expressed positions of stakeholders are discussed below.

The Perceived Need For Exclusive Practice Legislation

Although exclusive practice legislation is currently the subject of extensive discussions, for the nursing discipline this legislation came about serendipitously as a result of a policy goal of the Alberta Association of Registered Nurses (AARN) to have mandatory registration for its membership. Historically, there had been legislative activity in the late 1960s which was perceived to alter the authority of the AARN to register and discipline nurses. Although the bill was overturned, it served to alert the association that there was a need to consider mandatory registration for its membership. As one of the members of the Association pointed out:

> Public protection can only be achieved if you have the members of your profession subject to the rules, the standards, the positions of the profession on practice. So unless the organization, the professional body, has jurisdiction over its members to apply those standards and to expect and enforce conduct, you don't have any assurance that you can offer to the public that you actually have that mandate or the ability to carry out that mandate. If it's a voluntary registration by members, you could have all of the up-to-snuff, up-to-standard professionals registering and all those who aren't, not registering. (NP3, pp. 1-2)

Up to the 1970s, the Registered Nurses Act provided for protection of title and permissive registration. Although there was nothing in the act that required registration with the Association, the perception of the majority of membership was that this was in fact a requirement to practice nursing. In essence, the legislation was a "little four-page act that gave the AARN authority to register and discipline nurses, but there was nothing to say that nurses had to be registered" (NP5, p. 1). In anticipation of the need to achieve mandatory registration, there was a "flurry of activity" in the 1970s to develop a position paper describing the practice of nursing, although no official overture had been made to government to have the act revised (NP5, p. 1).

In 1981 the United Nurses of Alberta declared a strike. In the settlement negotiations, registration became a central issue from two perspectives. One of the bargaining items in the negotiations was a request from The United Nurses of Alberta (UNA) that the salary differential between graduate nurses and registered nurses be reduced or eliminated. A second bargaining item referred to the elimination of an employers' right to require registration as a condition of employment. As a representative of the Association explained:

> Registration at the time was seen by the union to be an infringement on human rights. However, most of them [employers] did require registration as a condition of employment or include in advertisements, "eligible for [registration]." But it was well worth nurses' while to be registered because of the salary differential: that was the biggy. It certainly made a difference. So UNA wanted to eliminate that, thereby taking away any incentive for nurses to be registered. (NP5, p. 2)

The strike ended by nurses being ordered back to work. The resultant arbitration hearings ruled in favour of the employer's right to request registration as a condition of employment and in favour of keeping the salary differential between graduate and registered nursing status. The outcome of the hearings was considered by the Association as a victory for the profession. "Registration will no longer be on the bargaining table" was a statement recalled by a participant as one which reflected the desire of the Association to resolve what had been a turbulent time (NP5, p. 3). In recognition of the ease with which registration could become a bargaining item, the Association made the decision to formally approach government to open the Registered Nurses Act, with a view to having mandatory registration. As one member described it, "That was the big, big issue. There were several issues that eventually came out, but mandatory registration was . . . the bottom line" (NP5, p. 3).

The AARN then hired a legislative consultant to draft the proposed legislation. At that time, and under the advisement of the consultant, it was thought that the best way to achieve mandatory registration was to tie it to nursing practice rather than to education requirements or to use of a title. As a representative of the Association indicated, "If you are going to make something mandatory, you have to tie it to something so you are able to say that if you are going to do this, then you must be registered" (NP3, p. 2). However, in defining a scope of practice it became apparent to those on the Legislation Committee of the AARN that an exclusive scope of practice would be necessary to define nursing as a discipline distinct from other health groups.

The drafting of a new Nursing Profession Act took place over a three year period amidst input from the membership and much inter-professional consultation. Reference to the notion of promoting health was challenged by most other disciplines and was eventually deleted as exclusive to nursing. Physicians took exception to any reference to the diagnosis and treatment of disease, since this was traditionally considered their exclusive scope of practice. Eventually physicians were agreeable to similar activities appearing within the exclusive scope of nursing practice provided the description of activities was prefaced by a reference to the application of nursing knowledge. When the *Nursing Profession Act* was finally approved in legislation January 1, 1984, the three exclusive practice clauses were: the application of nursing knowledge in caring for the physically and mentally ill, caring for and assessing the health of well persons, and the administration of medications [I(f)]. The latter clause was included at the recommendation of the executive assistant to the Minister of Professions and Occupations at the time to distinguish the role of the RN from that of other groups. As anticipated by the Association, this clause was later to create problems for non-regulated persons and was subsequently deleted from the Act in 1987. In speaking of the role of the executive assistant and the legislative process, a senior member of the Association recalled that

> his job was to steer it through caucus and the legislature. There was an awful lot of work that goes on before a bill ever hits the legislature. We worked with bureaucrats a lot at the beginning before he even had anything to do with it. And a bill can't ever go to the legislature until it's gone through the whole caucus in bill form, so there were all of these things that were done behind closed doors that nobody really knew anything about. (NP5, p. 7)

The passage of the *Nursing Profession Act* represented the culmination of numerous meetings with Association staff and lawyers, bureaucrats, politicians, the membership and other health profession groups along with a vigorous letter-writing campaign to MLAs by nurses who supported the new Act. As one interviewee recalled this latter activity eventually prompted a response from government admonishing the Association to "pull the plug on the letters. No more!" (NP5, p. 7). However, it was also a time in which the membership were united in their pursuit of a common goal. As described by an interviewee,

> It was one of the first times that the membership really got mobilized and really excited and politically active. And so there was general rejoicing, with this proclamation of an act. . . . There was a lot of emotion tied up with it too. It seemed to be bringing nursing into the twentieth century and in line with what we call "senior professions" like medicine, law, and dentistry, because we had our own act. It was a big act, too, with a scope of practice that was our own . . . with the ability to develop practice standards, to do other things related to public safety, and for the profession itself. So there was general rejoicing. The nurses mobilized. (NP5, p. 7)

Interpretation of the Exclusive Nursing Scope of Practice to Other Disciplines

Discussions about the interpretation of the exclusive practice clause in the Nursing Profession Act inevitably focus on the generic, non-specific nature of the wording. Nursing as a discipline has had historic difficulty defining precisely and descriptively what nurses do. Therefore, it is perhaps not surprising that those who have been most central to the activity of defining nursing would return to this long-standing difficulty. This was best described by a nurse who was recounting her experiences of working on a national research project which included the examination of scopes of practice for several health care groups. In her words,

> Nursing has the broadest scope of practice, the least specific scope of practice, and in some senses the most generic scope of practice. We know that it's difficult to describe what nurses do. If we ask the public, they can't tell us what nurses do. They say, "They're nice. They took real good care of me." But when you ask them specifically what they [nurses] do, they can't tell you. If you ask a nurse what she does, it's very hard to describe. (NP4, p. 9)

Another interviewee with many years of nursing experience including independent practice, reflected on similar difficulties in attempting to define nursing practice, even amongst colleagues:

> I find it very difficult even explaining within the nursing realm exactly what nursing practice is. I think when other nurses try to define exactly what nursing is or nursing practice is, they have a lot of difficulty as well. Nurses in independent practice are asked to describe their nursing practice in relationship to the Act, and a lot of them have difficulty with this. From a practical perspective it's very difficult within nursing, and I think it's very difficult, then, to explain it to other health professions. (NP6, p. 2)

As another interviewee described it, "Nursing is very broad discipline, lending itself to a broad, general, and generic exclusive scope of practice" (NP4, p. 9). In comparing the nursing discipline to one such as physiotherapy, this interviewee described the scope of practice of the latter group as very "clean, dry, very specific" (NP4, p. 10). The 'difference,' as one nurse described it, was that "nurses do it all, or are prepared to do some aspects of all of it, except surgery. And in the far north they're even doing that. It's unusual to find another scope of practice that's so large" (NP4, p. 9).

The difficulties with definition were ultimately reflected in the phrasing of the exclusive scope of practice clause. Two of the three exclusive practice clauses (caring for the physically and mentally ill, and caring for and assessing the health of well persons) were the result of attempts to capture the broad domain of nursing. But as one interviewee stated, "It didn't capture it. It just added more confusion and ambiguity" (NP4, p. 9). The confusion seemed to center on the generic descriptors, yet in summarizing the pursuit of greater clarity, the same interviewee noted that, "If we make it more specific, we wouldn't give credit to what nursing does . . . because it simply can't be stated in twelve statements or less" (NP4, p. 9).

If the exclusive scope of practice seemed ambiguous and nondistinct to those in nursing practice, it was a perception that was not shared by other exclusive health professions. In fact there seemed to be little, if any, voiced concerns amongst the traditional professions once the nursing legislation was enacted. As one interviewee described it, "Other professions were supportive . . . and the pharmacists looked at it very closely because their legislation coming in some time later actually was based on the same kind of model" (NP4, p. 10).

Interviewees attributed the response by other professions to the exclusive nursing legislation to several factors. The first factor related to the inclusion in legislation of the phrase "the application of nursing knowledge" [Nursing Profession Act, I(f)]. Although the phrases 'caring for the physically and mentally ill,' and 'caring for and assessing the health of well persons' were generic to all health professions, the exclusionary aspect of these clauses was encompassed in the reference to applying nursing knowledge. This deceptively simply phrase, then, became the key factor which allowed all other traditional disciplines to carry out similar, if not identical, functions using their own body of professional knowledge.

The second factor which ameliorated restrictions on other professions related to the wording of free-standing acts. All of the traditional health professions, including those with umbrella legislation under the current *Health Disciplines Act,* were legally entitled to practice within the scope of practice that was described in their legislation. Therefore, despite overlapping functions between disciplines, each discipline was allowed to practice within their defined scope without restriction or interference from other professions (NP3, p. 5).

The third factor pertained to the legal restrictiveness of the nursing exclusive practice clause itself. With the exception of one person who was practising nursing without a license, the Alberta Association of Registered Nurses has never engaged in a legal challenge generated from an interpretation of the exclusive scope of practice. As one interviewee explained it, "Despite the pressure that the AARN has been under by some groups that would really like to serve injunctions, . . . it has always fallen back on the fact that [they] don't think exclusive nursing practice has any teeth" (NP5, p. 15). As another interviewee described it,

> I think that in my opinion they [first two clauses of the legislation] were almost meaningless because they were so broad, and all providers knew that all providers in the health care system were providing care to someone who either had a physical or a mental need. So those statements . . . never needed much interpretation really. Because they were not questioned, they didn't cause problems. (NP4, p. 6)

While the first two clauses of the exclusive scope of practice seemed to have caused little concern, at least for the traditional professions, the third clause was more controversial. The giving of medications was the one act which nurses seemed to be able to most clearly identify with (NP4, p. 3). According to an interviewee knowledgeable in nursing legislation, the inclusion of medication administration as an exclusive nursing function reflected the importance of the activity to nurses and the need to protect the public from unregulated workers (NP4, p. 3). An additional and perhaps more significant precipitant coincided with a shortage of registered nurses. Certified nursing assistants (later called licensed practical nurses) were being delegated tasks traditionally carried out by registered nurses. The concern over the shortage of registered nurses and the perceived need to retain certain functions was described by an interviewee.

> The greater the shortage we had [of registered nurses] the more the scope of practice of registered nurses was overlapped with the scope of practice that certified nursing assistants could provide. And so it makes sense that if you're trying to use CNAs to provide nursing care in a time of shortage, that you protect or you clearly identify which activity they cannot do because they don't have the preparation, and medications was the one. So it made sense that it was protected at the time. (NP4, p. 4)

However, shortly after the Nursing Profession Act was proclaimed in 1984, it became apparent that medication administration was not an activity which could be retained exclusively by nurses. Workers in long term care facilities were being asked to give medications to patients which had been prepared by the registered nurse on the unit (NP5, p. 13-14). Day care workers and school teachers were routinely being asked to give medications to children at the request of absent parents. In the latter case, some teachers and school secretaries actually endorsed the nursing legislation since they did not want to assume such responsibility (NP1, p. 2). In other instances, questions taken to the extreme focused on the legality of giving medications to a sick family member. As a result of these circumstances, and as one interviewee said, the realization that "the whole world gives medications and therefore it is not an area for exclusive scope of practice for nurses," the clause referring to the administration of medications was deleted from the Nursing Practice Act in 1987.

The interpretation of the exclusive nursing scope of practice in relation to the role of the LPN is one which is inclusive of a long and convoluted history, marked by evidence of 'credential creep' and efforts to continuously expand a scope of practice. The sometimes turbulent relationship between the registered nurses and the licensed practical nurses is related to the overlapping scope of practice of these two groups. The relationship between the registered nurse and the nursing aide category of worker dated back to World

War II when the persistent shortage of nurses, otherwise engaged overseas, prompted the training of nursing aides as a temporary measure until nurses returned from overseas (Alberta Association of Registered Nurses, Minutes, 1943, p. 552). As the benefits of subsidiary workers became apparent in subsequent years, nursing aides were gratefully retained and, with additional training, a group differentiated themselves as certified nursing assistants. As described by an interviewee, the clause that guided much of the provision of care within nursing, was the reference in LPN regulations which required that LPNs provide health services under the direction of a registered nurse, a registered psychiatric nurse or a physician and within the policies of the employer (NP4, p. 6). With the introduction of exclusive nursing practice for registered nurses, the role of the LPN, as a delegated function, remained the same. Because the LPNs were governed under the Health Disciplines Act, they were exempt from the *Nursing Profession Act*. However, the important element which remained in LPN regulation was the supervisory role provided by registered nurses and other health groups. One interviewee best described the meaning attached to the supervisory role of the registered nurse.

> That clause carried a lot of weight with the registered nurses, with the LPNs, with the institutions, and with government, so that those first two generic clauses in exclusive scope really didn't become a problem because it was the registered nurses that were supervising the care. . . . The clause that really caused the problem was the medication one. (NP4, p. 7)

The 'medication issue' is one which has been a 'thorn' to registered nurses and one which almost all interviewees spoke about. At the core of the issue was the knowledge that LPNs were administering oral medications in long term care facilities. Some registered nurses felt this was in contravention of the exclusive nursing scope of practice; others felt that LPNs were not competent to perform this function. However, as one of the interviewees pointed out, the explanation by the Association regarding this activity always revolved around the interpretation of 'the application of nursing knowledge' within the nursing exclusive scope of practice. In her view, a skill such as giving a medication to a patient could be taught to a provider, but the underlying knowledge base was what distinguished the professional from para-professional groups. In her view, "The knowledge that was always there for the assessment and planning of care and the evaluation of care, and the implementation piece, depending on the nurse's best judgement, could be done by somebody else" (NP5, p. 12). Although this explanation was adhered to by the nursing association, and returned to many times, not all the membership shared this viewpoint. As a nursing union spokesperson described it, "The issue of LPN administration of medication has been a serious and expanding problem" (NP1, p. 3).

Expressed Positions of Stakeholders

While the legal interpretation of the exclusive scope of practice has been relatively straightforward for the nursing group as well as the other traditional health professions, the perception of the intent of the nursing legislation has varied. All nursing interviewees believed that the introduction of the exclusive scope of practice was more reflective of the acknowledgment of nursing as a profession rather than as a significant means to exclude other practitioners from a defined jurisdiction. As one nurse interviewee described it,

> I don't think that our legislation is restrictive almost at all, even though it was called an exclusive scope of practice. While it may not have given us a lot of sort of closed-parameter domain, I think it gave nursing a sense of pride in profession, that nurses and nursing could look at their piece of legislation and their exclusive scope of practice no matter what the wording was and say, "This is our profession." I think that it went a long way to kind of propel nursing forward. (NP7, p. 2)

As another interviewee noted,

> There are all kinds of pride and cultural things that have built up around having an exclusive scope of practice which are also very important to the profession. . . . Many of our members hold that exclusive scope of practice

> dear because it's an achievement for nursing, because it's almost like an icon or a symbol of professionalism. (NP3, p. 3)

For some nurses the exclusive scope of practice did not reflect what had always occurred in the workplace. There seemed to be a recognized delineation of roles along with evidence that certain tasks had gradually been delegated from registered nurses to licensed practical nurses without apparent resistance. Speaking of her perception of how these roles had evolved, one interviewee explained it this way.

> There seemed to be a sense that people understood the division of activities and tasks, accountability, responsibility, and reporting. There was never any real tension. I don't believe that generally across the province there was confusion about who was to do what and who was accountable for what. Health care, from my perspective, has always been an evolution, and perhaps that's what's making this [the proposed changes] so uncomfortable. Through evolution, registered nurses have taken on more activities and responsibilities, and so too have LPNs, but it's been a . . . slow process. (NP1, p. 5)

Views differed as to whether the advent of the exclusive scope of practice sensitized the licensed practical nurse group to the possibilities that their role would be diminished or eliminated. As one of the interviewees recounted, there was a significant promotion of all-RN staffing emerging in North America in the 1980s. She recalled being told by a Director of Nursing that LPNs were ill-equipped to work in the "high-tech new facility" and that all-RN staffing provided higher productivity at lower cost. Reflecting on the return to the use of LPNs, she noted that "I find this very ironic now that we're in the '90s and it's a completely different story" (NP1, p. 4).

With the emerging popularity of an all-RN model of staffing, the Professional Council of Licensed Practical Nurses responded to their "perceived imminent elimination" by making themselves recognized as being valuable contributors to health care (NP1, p. 3). Several interviewees noted, and some commended, the systematic way in which the Professional Council of Licensed Practical Nurses had pursued this goal. On reflection, one registered nurse attributed the campaign, which in her view had been evident for approximately 10 years, as having been "incited" by some nurses when in fact "others were comfortable with a mixed environment" (NP1, p. 3).

More recently, the Professional Council of Licensed Practical Nurses has proposed changes to their regulations which would expand their scope of practice to include several tasks, e.g., administration of intramuscular injections, infusions, physical assessments, which would be included in a 'high-intensity program' (United Nurses of Alberta Brief, 1996). Both the AARN and UNA have been united in their opposition to this proposal (p. 4). In a letter dated June 21, 1996, to the Chairman of a Regional Health Authority, both groups stated that "[we] cannot condone the development of a program that could prepare health care workers to practice in a way that may jeopardize client safety." A representative of the Professional Council of Licensed Practical Nurses responded by saying, "We are confident the knowledge and skills taught in the program are all within the parameters of the LPN scope of practice and the current Regulations." In reference to the 'high intensity program,' this spokesperson went on to explain that

> the role of the Licensed Practical Nurse is complementary to that of the Registered Nurse. It is not currently, nor is it proposed that an LPN would be an independent practitioner. With the ever changing health care environment, we believe it is essential for the LPN to have increased knowledge and understanding to continue their contribution to care delivery.

THE ELIMINATION OF THE EXCLUSIVE PRACTICE CLAUSE FROM THE NURSING PROFESSION ACT

In discussions with interviewees regarding the proposed elimination of the exclusive scope of practice, respondents inevitably reflected on the broader perspective of reforms to health profession regulation. Of necessity, these reflections are framed within a linear description which would be more accurately represented by a complex and interrelated series of contravening variables. The following discussions, therefore, is a presentation of the three factors which all participants linked to the elimination of the nursing exclusive scope of practice. The additional factors discussed are those which were described by individual participants.

Economic Factors

All of the interviewees believed that reducing health care costs was the major factor driving change in health profession legislation. One of the interviewees was mindful of an ideology which the newly elected Premier had espoused shortly after the election in 1993, and one which was to spotlight government involvement in regulatory practices. "We've got to learn how to steer the boat and not row the boat," was the claim made by the Premier (NP5, p. 19). Accordingly this statement was broadly interpreted to mean that the government wished to "get out of the business of doing business, and to get out of the business of providing services" (NP5, p. 19). In her analysis of these statements she concluded that

> It was economically driven more than anything, . . . this notion that we [referring to government] needed to do something about those health care professionals first, because there are a heck of a lot of them, and they were costing the health care system an enormous amount of money because of the monopoly that was held by some of the senior professions, . . . and the monopoly is caused by exclusive scopes of practice. (NP5, p. 19)

Another interviewee expressed similar sentiments, although was sceptical about the outcome.

> I can't help but feel that it was initially being driven by what people perceive to be a way to meet the fiscal agenda. And, I'm saying *perceived* . . . because I don't believe it will meet the fiscal agenda. (NP7, p. 3)

Although this interviewee and other respondents believed that the primary impetus for the proposed changes to health profession legislation occurred at both political and bureaucratic levels of government, several interviewees felt that employers had also become a significant pressure group. With the increasing realities of fiscal restraint, employers were also seen as having 'bought into' any proposed attempts at cost-reducing strategies, particularly any means of utilizing less costly workers (NP7, p. 4). In stating her view, she noted that

> [A well-recognized bureaucrat] has been one of the biggest promoters of models of delivery of care with generic health care workers. So, if you have employers who are looking for models because they believe there is a way to do it [save money], and we have people within the government department steering them in certain directions, then you're going to get some momentum built up. (NP7, p. 4)

Barriers to Service Delivery

Closely associated to discussions of economic rationales were also those which related to the perception of barriers created by exclusive scopes of practice. However, several of the interviewees were particularly forceful in their view that the nursing exclusive scope of practice had been misinterpreted. Although none of the interviewees defined the term 'barrier,' it seemed clear that the term referred to one of three circumstances: lack of flexibility in allocating health manpower, the inability of the public to select health care services of their choice, and the inability of the public to select providers of their choice.

In discussing the relationship between health care budgets and the proposed elimination of the nursing exclusive scope of practice, one interviewee, expressing the sentiments of several others, noted that with less availability of actual dollars to put into providing care in the system, employers were forced by government to look at 'the bottom line' because

> government is saying, "You have this set amount of public funds to spend, and you, employers, must provide X number of services, and do it within that dollar amount." So the pressure is on employers, and employers then apply pressure to get the changes that they believe they need. (NP3, p. 8)

Under the pressure of reducing costs, employers were seen to be frustrated with what they perceived as barriers created by professional legislation which limited the deployment of manpower and the utilization of less costly workers.

> Exclusive scopes of practice are definitely barriers to employers. They can't use their employees any way that they want to, and it costs them more dollars to have . . . these specified professionals provide the care that the organization is mandated to do. If they want to have a nursing aide do something, they don't want an exclusive scope standing in the way if there is no proof that doing that is unsafe. If they want to have an LPN . . . giving medications, then why should they not be able to do that if exclusive scope has not stopped unsafe practice and if there is no proof that doing that is unsafe? (NP4, p. 11)

Thus, her conclusion was that

> it makes sense that exclusive scopes of practice [in Alberta] are now seen as a barrier to health care reform, because you can't reform the system if you can't get those professions to make some changes in what they do and how they do it and how they relate to each other and how the employer can use them and how the public can access them. (NP4, p. 14)

While this comment may have reflected the restrictiveness of exclusive scopes of practice, in general, many of the interviewees emphasized that, in their view, the nursing exclusive scope of practice was different from that pertaining to other professions.

> Again, the AARN's view is that they don't need to change the Nursing Profession Act because it doesn't in fact carve out a territory that is unencroachable. It's a matter of understanding. A lot of employers do believe still that the exclusive scopes of practice of the health professions were their problem. (NP3, p. 8)

Drawing on circumstances in health care over the past three years to emphasize what she believed to be the fallacy of such beliefs she pointed out that:

> recent events show that they [employers] didn't have to [press for elimination of exclusive scopes of practice] because they have achieved their bottom lines. They have turned the economics of health care upside down and landed on their feet in some sense. But the fact is, the economic part of it they have achieved, and health legislation has not changed. So, how did that happen if health profession legislation was the barrier? (NP3, p. 8)

Factors Related to Public Choice

The need for the public to have greater choice in the services and the providers they wished to have access to was seen by several interviewees as another significant factor in the proposed changes to health profession legislation. One of the interviewees who had attended one of the Health Roundtable discussions described what she heard in relation to public choice and greater access to services. This interviewee, as did others, also voiced her scepticism over what the term 'public choice' meant and the rationale which usually accompanied its usage.

> The first roundtables on health repeatedly talked about legislation as a barrier. The real barrier, it was seen to be, was public choice. "We've got to do this because the public wants and needs more choice." I don't know where that perception ever came from. Except for perhaps people who wanted chelation therapy or recognition of some alternate therapies, I've never really heard the average citizen in this province saying, "The registered nurses having an exclusive scope of practice is something I'm really bothered about." But that was the number one reason to give what the public wanted, which was choice, and remove legislative barriers. (NP1, p. 9)

Disbelieving of the merits of this rationale, she pointed out that

> I don't think there was any credibility to that argument. It was a justification that was seen to sort of trigger certain reactions in the public, that "we [government] are the defender of liberty and your right to choose." (NP1, p. 9)

Another interviewee was also puzzled by the rationale surrounding the need to improve public choice.

> I don't know if it's a government-generated term. One would have to assume that it is, given that it was in the first document [referring to New Directions for Legislation Regulating the Health Professions in Alberta: A Discussion Paper], but nongovernment people seem to be confused as to what the reference there is. I can't really think of other choice that they would want. (NP7, p. 7)

In addition, she was reserved about the outcomes of increased consumer choice. With mixed support and a good deal of uncertainty as to exactly what was being proposed, she stated,

> I am a true believer in the appropriate provider providing the appropriate care in the appropriate setting, . . . but some of the things that they have been proposing, it's sort of like buyer beware; . . . somehow they're [consumers] now going to interview their care providers and decide whether they are appropriate to give them the care that they need, and that's unrealistic. (NP7, p. 7)

In discussing the perception that removing exclusive practice clauses would facilitate public choice of service providers, another interviewee expressed similar reservations about the ability of the public to make informed choices. She was supportive of the right of the public to choose but believed that there were necessary prerequisites.

> I think the public has the right to choose but, in order to choose, I have to have information and I have to understand what is nursing, what is physiotherapy, what is dentistry. And I don't think our public really understands. I think there still is a lot of misinformation about the health care system. I think there is the perception that the physician is the primary

> person and so at least in our older population I think it's going to take a lot of something before those ideas can be changed. (NP2, p. 6)

One of the interviewees challenged the terms *flexibility* and *public protection* when used to justifying the need for legislative change (NP3, p. 9).

> The reasons that are given on paper is flexibility and public protection. Flexibility can also be taken to mean that the public should have choice. But I think it's rhetoric. Economics is really what flexibility means. (NP3, p. 9)

Her interpretation of the intent of such principles was that present nursing legislation restricted the hiring of less costly workers; yet, in her view, "Our legislation hasn't changed from what it was so it must be possible without changing it" (NP3, p. 9). Public protection was another principle which the same interviewee felt had presented some legitimate concerns in relation to existing legislation and that the AARN had acknowledged a need "to open that piece up" (NP3, p. 12).

> Public protection means transparency, that the professions are not doing their own thing behind closed doors with impunity. In our legislation existing currently, that openness is not there, and it was deliberately designed not to be there so that our members also were protected. So there are lots of good things about the proposed changes. I'm not sure by design, but there are. (NP3, p. 12)

However, what was less defensible as another rationale for changing legislation was the need for the public to understand the regulatory system. In supporting the principle but not the method, she stated that,

> I believe that it's very important for the public to be able to understand how self-governance works and how to access it. [But] when I think about twenty-nine professions who are all going to be controlled under one piece of health professions legislation, and the complexities of that and the complexities that we already see in the drafts that are coming out. . . . I don't believe the public will understand any better, but government will be able to say, "We fixed those professions; you won't have to worry about it

> any more. We've redone all their legislation, we've answered your complaints, and now everything's open, and we've done it for you." (NP3, p. 13)

Additional Factors

Several interviewees suggested that an ideological factor of anti-intellectualism and anti-professionalism may have played a role "in the mind set and philosophy of this government" (NP1, p. 8). As one interviewee commented, "I always had the sense that there was a fairly anti-elite, anti-intellectual view" (NP5, p. 24). Attached to a perception of anti-intellectualism, also was the notion of anti-female.

> I think it has to do with the fact that we're about a ninety-seven percent female workforce who are well educated and not badly paid, and that doesn't really fit with the philosophy of some of the drivers in this government. . . . "These women should know their place." (NP7, p. 4)

Others suggested that changes were initiated, in part, because the original intent of the exclusive practice clause had not been realized. As a former consultant to the Alberta Association of Registered Nurses described it,

> The exclusive scopes were set up supposedly to protect the public, but the public still had problems with professionals. Events were still occurring in which the public supposedly was receiving unsafe care in spite of the exclusive scope of practice. So exclusive scope wasn't doing the job from the point of view of the public and government that it was set up to do. (NP4, p. 11)

Another respondent believed that, government, as the oft-time recipient of complaints from a dissatisfied public, was compelled to consider why it was called on to resolve professional-client issues, when the professions had been delegated the authority to be self-governing. "I complained about this person to that professional body and nothing happened. They just covered it up" (NP3, p. 7). This interviewee believed that complaints such as these evolved into what she termed the "employer movement, . . .

where the perception was that the professions are really using exclusive scopes of practice to carve out their own little territory. That's a very real perception" (NP3, p. 7). Nevertheless, in disagreeing with the legitimacy of this perception in relation to nursing, she pointed out that "nursing's exclusive scope of practice couldn't possibly carve out a little territory because it isn't something that you can take to court and defend that it is or it isn't within that description of exclusive scope of practice" (NP3, p. 7).

Two of the interviewees also noted the influence from other provinces who had preceded Alberta in their attempts to revise professional legislation. One of the respondents pointed out that similar reforms had been implemented in Ontario, British Columbia and Manitoba and that it was "typical of our Conservative government to follow what's happening in other provinces" (NP, p. 5). Another described events this way: "When Ontario burps, the rest of the country pays attention" (NP4, p. 12). However, another interviewee felt that clues to the eventual health care reforms were evident in Alberta prior to the change in legislation in Ontario.

> In the '80s there was a rustling around amongst certain MLAs and government in response to some public pressure that somehow the professions had an awfully good deal. There was a notion that although the professions were charged with making sure that standards were upheld and that their members were acting in the best interests of the public, . . . somehow a grassroots kind of awareness started to come. We think it was [named two other professions] but we can't really say that positively. This was what began to produce that government thing. (NP3, p. 6)

Globalization and the North American Free Trade Agreement were considered to be somewhat influential in restructuring professional legislation and professional distinctions at least within North America. "I don't think we are immune to those activities" (NP1, p. 8). Tied to these influences was what one interviewee described as a government agenda of 'deskilling' which she felt had been apparent in the federal government for approximately 7 years and in Alberta since 1993 (NP1, p. 8). Evidence of this emerging view she claimed was substantiated by the attendance of representatives of Alberta Health at an American conference in which there was "a real promotion of the lesser skilled, cross-trained person." The significant message that attendees received was that

> you don't need a registered nurse with boundaries in terms of practice when you can have a multiskilled generic worker who, if you just remove the legislative barriers, can do anything. And this government is particularly keen on eliminating barriers for business . . . and regulative legislation is seen as a barrier. (NP1, p. 9)

According to this informant, this was a timely message in the early 1990s for employers who were increasingly concerned with budgets. "Employers started investigating these possible alternatives" (NP1, p. 10). Shortly thereafter, then Minister of Health, Nancy Betkowski, initiated the first significant budget decreases to health services promoting the need for less costly community-based alternatives to care delivery. As this informant noted, the community workforce constituted a few registered nurses, and a predominance of unskilled providers. At that time clients were described as "low-intensity," a circumstance which she claims has changed without the commitment changes in skilled manpower (NP1, p. 10).

Increasing Access to Service

Although barriers in health services were considered to be related to the perception that removing the exclusive scope of practice would improve allocation of manpower and improve access to services, several interviewees described circumstances which presented barriers to the public which would not necessarily be altered by changes in professional regulation. In recalling discussions at the AARN Legislation Committee, one interviewee noted that there had been little reference to restrictions between professional groups; however, there were restrictions arising from other Acts and from funding agreements (NP7, p. 8). The *Hospitals Act* placed restrictions on what services could be publicly funded and the *Canada Health Act* made no reference to home care services (NP7, p. 8). In expressing her view that funding of services was a more important determinant of service access than redefining professional jurisdictions, one of the interviewees described what she considered to be inappropriate funding of in-home therapies.

> One of the things we have is home parenteral therapy, . . . and then we don't cover the cost of the drugs for the people to be able to go home and have it. It doesn't make sense. And I'm hearing that [for seniors] oxygen is not being covered at the full cost. So, to me, these are the things that cut down on the choices for the public and the flexibility . . . and for employers. (NP7, p. 9)

Midwifery was seen as another "excellent example" wherein women wished to access a service, yet were restricted from doing so because of lack of public funding (NP2, p. 7).

Other interviewees noted that *The Pharmaceutical Act* restricted the prescription of medications to physicians, a regulation that had particular significance for nurses wishing to advance into extended practice areas (NP2, p. 6). Institutional policies were also cited as limiting the independence of practitioners. In a hospital with which one of the interviewees was familiar, it was a policy that "every medical directive has to be approved by a physician, even though it may be the nurse who initiates all of the actions and the physician comes along and signs them" (NP2 p. 6). With reference to the rationale for needed changes to health profession regulation, it was her conclusion that "we can talk choice all we like. But until people change some of the policies and the Acts or legal barriers, I think its nice talk, but not something that probably is ever going to amount to a lot" (NP2, pp. 6-7).

Expressed Positions of Stakeholders

Discussions with interviewees about the response of stakeholders to the proposed elimination of the nursing exclusive scope of practice inevitably elicited strong, emotionally-laden responses. A clear response to the proposed elimination of the exclusive scope of practice was made by a spokesperson for the AARN.

> It was certainly the best effort at the time and it worked very well for us. We would *not* be giving it up now, voluntarily, if government did not have an agenda to get rid of all the exclusive scopes of practice. Exclusive scope of practice for registered nurses does not impinge on anyone else, and therefore we do not agree that you need to remove it. (NP3, p. 7)

From discussions with several interviewees it was apparent that the inclusion of the exclusive nursing practice clause represented more than a legislative change; it had become symbolic of the professionalism and perhaps the prestige, which nursing had been striving for. As one interviewee described it, "It was some kind of prestige to have free standing legislation, to have your own Act. Then it was a bit more prestige, if you had exclusive scope of practice" (NP5, p. 25). In other senses, it was perceived to be the primary means by which the public was assured about the quality of services they received. And in a further sense, and particularly at a time of turbulence in the labour force, it was seen to provide a degree of job security. Each interviewee acknowledged that many of the perceptions surrounding the meaning of the exclusive scope of practice in nursing had been misinterpreted; however, it was those perceptions, factual or otherwise, which formed the basis of the responses.

One of the most sensitive and predominant areas of discussion was the role of licensed practical nurses and how that role could potentially change with the elimination of the exclusive practice clause. One of the interviewees, with long-standing involvement with staff nurses, described what she considered was a "huge perception out there that the change to the exclusive scope of practice will open it up to the others [LPNs]." However, her personal response was that "I don't believe that's true" (NP7, p. 9). In her view, since LPNs were not claiming to be applying nursing knowledge they were exempt from nursing legislation. In her view it was the terminology rather than the content of the phrase 'exclusive scope of practice' which lent itself to misinterpretation, not only by the membership but also by "the bureaucrats and those on the Workforce Rebalancing Committee" who applied a literal interpretation to the phrase (NP7, p. 10).

However, the interpretation of exclusive scope of practice from a nursing perspective was only part of the issue. One interviewee felt that the response by nurses to the elimination of the exclusive scope of practice had to be considered within a broader context.

> I think that nurses feel, rightly or wrongly, that somehow we've given up something. And I would have to say that I think we're seeing a response probably to the fact that in all sectors nursing has taken such a beating that they look at this and say, "And now our exclusive scope of practice is gone." And I think this is once again a putdown. I think our nursing profession is suffering right now from being downtrodden, and I think that people really do feel that they've lost a great deal of professional identity. However, I think it is a perception, and however we can get over it, I think it has more to do with an abuse syndrome than anything else. (NP7, p. 10)

One of the interviewees pointed out that changes in the LPN regulations, which allowed LPNs to administer medications, occurred about the same time as this task was deleted from the nursing exclusive scope of practice, and has continued to be a very controversial subject amongst registered nurses.

> It still sticks in the craw of many registered nurses, . . . the provision of LPNs to administer medications, period. It's still a big, big issue with many of our members. They have never accepted the change, they have never believed that it was appropriate, and they're still angry, and you still hear it. And the MLAs still hear it from registered nurses. (NP3, p. 14)

Although there has been historic pressure by some members on the AARN to "to do something about it [the role of the LPN]," in the view of an interviewee representing the Association, much of this pressure has emanated from a misinterpretation of the nursing exclusive scope of practice and the role of the LPN.

> The official position of the AARN has been that as another profession who has its own mechanisms and its own standards in place, it is not the AARN's business to control whether that profession takes on another task, as long as they can prove that they're competent to do so. (NP3, p. 15)

Of particular concern to the Association, the interviewee was particularly concerned that, irrespective of the tasks an LPN was allowed to perform, a registered nurse or a registered psychiatric nurse continued to maintain the overall responsibility for nursing care.

> We have no problem with the LPN taking on additional tasks but in the overall picture the nursing care must still be planned, decided, the provision of that, who provides it, what's provided, how it's evaluated at the end and its effect, and all of that must remain under the domain of the registered nurses. (NP3, p. 17)

Although the concerns of the AARN with the role of the LPN have been heightened with the recent proposed changes to the LPN regulations, not everyone agrees that the gradual enhancement of the LPN role is an issue. There are staff nurses who publicly support expanding the role of the LPN and publicly chastise the Association for "striving to expand the role of the RN while it opposes other health care professions doing the same." The view by this group of the LPN as a co-worker was that

> LPNs are a well educated, licensed, regulated group of health care providers. They are prepared to work in an interdisciplinary team, under the direct or indirect supervision of an appropriate health care professional. LPNs are working very hard to meet new standards of education, . . . to ensure currency and competency in *their* practice. (McDonald et al., 1997, p. 6)

Disagreement with the views of the AARN on role expansion for the LPN have extended beyond the membership. In describing the response of government to the expressed concerns of the AARN, a union spokesperson indicated that the consistent response to both the Association and UNA was that

> you're just trying to protect your own turf, and we're not willing to listen to that because we know that while you're trying to protect your own turf, you're also trying to take away doctors' turf. That's what government has said. There is a real tension there. I think also there is a sense within some groups, perhaps the College [of Physicians], that there is a threat from nurses to their work as well. (NP1, p. 15)

Resistance to proposed changes in the Nursing Profession Act and LPN regulations by a portion of the membership have been acknowledged by the Association as particularly troublesome in light of recent changes in the labor market.. In describing the difficulty, a spokesperson for the AARN stated that

> one of our problems is that it's all been obscured by the readiness of people to believe that it's turf protection, that RNs don't want to lose their jobs. And some of our own members have inadvertently helped to contribute to that notion, because of course they are worried about their jobs; that's a reality. (NP3, p. 17)

This same interviewee acknowledged that the concerns of the membership were legitimate but reiterated the position of the Association:

> I don't believe that masses of them are going to lose their jobs because I believe that registered nurses will always be needed. . . . However, it is a legitimate concern; it's just that it is not the AARN's issue. We are not here to decide who keeps jobs and who doesn't; it's deliberately separate from what our functions are. (NP3, p. 17)

However, the concerns of some registered nurses with recent staffing patterns is only part of what has been a long-standing perception by RNs of the inappropriate role of the LPN. In discussing the importance of providing a collective voice amidst diverging viewpoints, a spokesperson for the Association described the difficulties:

> There are many of our members out there who are still arguing about medications, and there are many who say there should never have been LPNs in an acute care hospital. They're not prepared; they don't have the education. And those things make it more difficult to put across the real

> argument because it's obscured by all of these other messages, by the readiness of other people besides nurses to say, "Oh, well, that's just turf protection." And so we're in this huge foofaraw about something that really isn't, I don't believe, unresolvable. But gee we have ourselves in a mess over it. (NP3, p. 18)

Not everyone was opposed to the proposed legislation changes. One of the interviewees felt that the proposed changes would bring about a welcomed "level playing field" in that all professions would have the privilege of being self-governing. In her view, this would mean that future changes in the legislation would be subject to public debate in the legislature rather than the seemingly impromptu changes to regulations which seemed to be the current practice (NP5, p. 28).

Within the Association membership, there are a group of nurses who support the changes in legislation, presumably including the elimination of exclusive scopes of practice. In a letter to the Editor of the July/August AARN Newsletter (1997), a group of twelve nurses, in response to a letter the membership had received from the AARN outlining proposed changes to the role of the LPN, voiced their support of the proposed legislation changes. (At least one of these nurses has worked with the PCLPN on curriculum changes.) According to McDonald et al. (1997):

> When a single Health Professions Act is enacted there may be a "blurring" of professional boundaries. Rather than legislating changes in the roles and responsibilities of the health care providers governed by the Act, it is hoped this new Act will empower all disciplines to work in harmony for the benefit of Albertans. Instead of eroding public safety, this Act will promote it, by charging each profession with the responsibility of ensuring its own members are current and competent to practice. (p. 6)

PERSPECTIVES ON ALTERNATIVE SOLUTIONS TO REMOVING BARRIERS BETWEEN PROFESSIONS

Introduction of Proposed Changes

Participants were asked to describe events which had taken place in relation to the introduction of proposed legislation changes.

Some interviewees suggested that, in their view, the first serious attempt at examining all of the professional legislation dated back to 1990 with the release of a government position paper entitled **"Principles and Policies Governing Professional Legislation in Alberta."** This policy paper was remembered by interviewees as emphasizing increased public accountability and transparency of regulatory processes. From a public perspective, nothing more was heard about professional legislation until the present government was elected in the Spring of 1993. In December of 1993, the AARN became aware, through discussions with Alberta Labour, that a government committee was being established to review and make recommendations on legislative changes for all health professions (NP6, p. 11). Shortly thereafter, a member of the Association recalled that a discussion paper outlining proposed changes mysteriously appeared on her desk.

> It was leaked by politicians, I think naively, knowing where the leak came from. It was a rookie, and I think he just maybe didn't know what an uproar it would cause. We didn't get it confidentially. . . . I don't know where it came from. (NP5, p. 20)

Her perception of the document was that

> it was a bad paper to begin with. There was no compunction about making sure the word got out because it was making all these faulty assumptions about exclusive scope of practice and how we didn't need that any more because it certainly protected the [professions]. (NP5, p. 20)

Expecting that there would be an official government discussion paper forthcoming, a group of current and former members of the AARN administrative staff met to plan future strategy. Anticipating that there was a need to "get our ducks in a row quickly, an Ad Hoc Committee on Legislative Changes was established in February, 1994 to develop an official Association position on the speculated changes" (NP5, p. 20).

In the Spring, 1994, the government established the Health Workforce Rebalancing Committee (HWRC). In recounting the events surrounding the formation of this committee, one interviewee noted that

> I can't tell you how many leaked copies we got all along the way: it was really interesting. The Health Workforce Rebalancing Committee, we knew it was going to be formed. We couldn't talk about it because it wasn't official, and this is good politics too, I guess, . . . but how often the membership changed on it; . . . and the agenda for the first meeting, we even had copies of that. It was just really an interesting process. (NP5, p. 22)

By September 1994, the HWRC had released a discussion paper entitled **New Directions for Legislation Regulating the Health Professions in Alberta** which formed the basis for discussion in subsequent public forums. In relation to the forums, a spokesperson for the AARN noted, "We were invited as a stakeholder, but we did *not* in any way precipitate it" (NP3, p. 19).

Approximately half way through the scheduled forums, it was apparent that there was a good deal of opposition to the document.

> If you look at when the HWRC was struck and when that document was released for discussion, it's fairly apparent that it wasn't the committee's document. When they began to get in trouble in the discussions about half-way through the forums, the committee distanced itself from the document and talked about it as a document drafted by the bureaucrats. (NP5, p. 24)

In response to concerns raised with the initial document, the HWRC released the **Discussion Paper II** in July, 1995. In the interim, the AARN, along with other groups, had made written submissions and oral presentations to the Committee. By November, 1995, a final Report, **Principles and Recommendations for the Regulation of Health Professionals in Alberta**, was released by the HWRC and was approved by the Ministers of Health, Labour, and Advanced Education and Career Development. Subsequent to the approval, a Health Professions Act Implementation Steering Committee was established. Reporting to this committee was an Advisory Committee on Restricted Activities to which the president of the Association was appointed.

The process to revise the professional legislation has extended beyond the completion date by several years as a result of an extensive consultation process. The AARN alone has submitted at least four 'response' documents to government, made at least one public presentation and attended a government-convened workshop to express their viewpoint. These activities have been in addition to regular communiqués to the membership outlining the stages of discussion and the need for the membership to oppose the legislation as proposed. The president of the Association indicated an enormous amount of time had been committed to the process by the Association. From the onset of discussions, deadlines were consistently extended.

> We have been told that the Health Professions Act will be introduced in the 1998 spring sitting of the legislature, . . . and it was pending the summer before that. I think part of it is that it's much more complex to change this kind of thing than anybody realized. (NP3, p. 22)

Although the majority of discussion with interviewees focused on the operation of the Health Workforce Rebalancing Committee, two interviewees suggested that the work of the committee was likely influenced by forces beyond Alberta.

> It isn't just about health care, and it isn't just about health care professionals. It's about the free market . . . and you can read it in some of the books from other countries who have gone through this. [It's] about the corporatization of all services and the attempt to disinvolve the public person as much as possible. I believe the same trend is here. I think there is . . . a will in Alberta to change a lot of things that have been publicly funded and protected through regulation. (NP3, p. 23)

Another interviewee believed that the "political lessons" to be learned from the current proposed legislation changes had been transported from two books, namely, *Unfinished Business* and *Reinventing Government*. In reference to the changes, her comment was

> I am sure it came from this whole ideology. I think that initially the idea for the reinventing of government . . . the economic reality that we were told about all had a major impact on this, and the Roger Douglas [author of *Unfinished Business*] idea of . . . elites . . . and making change fast, as was done in the restructuring, before anybody had a chance to react, was the motivation behind this. (NP5, p. 21)

However, it was her belief that because the professions were prepared for the anticipated changes, the consultation process proceeded as it did. As she described it

> I honestly think that if the paper hadn't been leaked originally and people were not prepared, that we wouldn't have had the big consultations that we had which made massive changes to the discussion paper that eventually came out as the final report of the Health Workforce Rebalancing Committee. (NP5, p. 21)

The Meaning of the Elimination of the Exclusive Scope of Practice for Nursing

The interview question pertaining to the meaning of the elimination of the exclusive scope of practice was of great interest to all interviewees. Responses to the question typically began as part of the social conversation prior to the taped interview and frequently carried on following the interview, and thus were lost as recorded information. Not every interviewee 'stayed on track,' preferring instead to expound on that which was most pressing and most personal. Because each interviewee had many years of nursing experience and direct involvement with nursing legislation, the discussions were lengthy and punctuated with passionate descriptions and predictions. There was a common concern for what was perceived to be a trend toward a less skilled workforce. Yet, each acknowledged that elimination of the exclusive scope of practice could not, of itself, be targeted as the primary motivation for such a trend. In reality, there were a series of events, each interrelated, collectively contributing to changes in the heath system.

One of the primary concerns for several interviewees with the proposed elimination of the exclusive scope of practice was the possibility that mandatory registration would also be eliminated. Since mandatory registration, and secondarily, exclusive scope of practice were perceived as a significant professional hurdle accomplished with the enactment of the Nursing Profession Act in 1984, it was not surprising that this would be one of the first subjects to be discussed. The concerns of several interviewees was best expressed by a former member of the AARN office staff.

> I saw that if we lost exclusive scope of practice, we lost mandatory registration, which would really inhibit the AARN's ability to protect the public from unsafe care, particularly with other trends that we were seeing which was the whole deregulatory stance out there. (NP5, p. 22)

The locus of concern was with the possibility of voluntary registration and the impact that would have on monitoring the standards of practice of the membership. A related concern was that employers would then have the right to choose manpower resources, and presumably would be attracted by a less skilled and less costly workforce when faced with reduced operating budgets. The trend toward deregulation was exemplified in the "whole notion that employers should be able to choose who they employ, and people should have a choice of whether they belong to groups or not" (NP5,

p. 22). These trends, she believed, would have "a serious impact on the AARN" (p. 22). As she explained:

> There was a real concern about membership reduction. The concern was there would be fewer people registered, and if you don't have registered nurses, the AARN doesn't have the jurisdiction over those people, . . . therefore, the profession becomes less and less self-governing. . . . The AARN, like any regulatory body, only has jurisdiction over those who are registered. (NP5, p. 22-23)

Another spokesperson for the AARN was emphatic that the exclusive scope of practice clause would be eliminated from all health legislation. "I would say it absolutely will occur. The government will on that one is unshakable" (NP3, p. 21). Her concern also focused on mandatory registration. It was her view that if mandatory registration was retained in the new legislation, then the impact of eliminating the exclusive scope of practice would be minimal. Although she had received reassurance from government bureaucrats that mandatory registration would be included in the new legislation, she was remaining cautiously optimistic until the Act was actually proclaimed. As she described it:

> We will find out much more down the road. Government says and has put in writing that it intends to ensure mandatory registration for every profession. So if that is so and if that is carried through, then the impact of changing the description of the scope of practice of registered nurses and not calling it exclusive scope of practice any more should not have a huge impact. I say, *if* and *when* . . . because I will believe it when I see it. Things can happen . . . at any point along the way, either in negotiations or without being negotiated, changes can occur. (NP3, p. 3)

When asked about the meaning of removing the exclusive scope of practice, another interviewee was succinct in her response: "In the big picture it doesn't mean anything. It does no harm to nursing, because it didn't make sense to have the very broad generic clauses in the exclusive scope" (NP4, p. 15). However, in referring to the meaning attached to exclusive scope of practice by the membership, it was her view that nurses in general had an emotional and a professional attachment to the legislation which was not commensurate with the utility of the regulation.

> Most of the discussion about exclusive scope was always very emotional, very territorial, and had very little rationale connected to it. But for the nurses who are involved in legislation and know about it, I don't think it would take very long for them to see through the emotional part to the rational aspect that the exclusive scope we had really was meaningless. (NP4, pp. 26-27)

In a lengthy discussion this interviewee went on to describe the historic difficulties in attempting to define what distinguished nursing practice from that of other health workers, and what the long term implications of this difficulty would be. It was her view that the important question was "What part, if any, of the scope of nursing practice is exclusive only to nursing? . . . since it has been very difficult for nurses to identify what that very exclusive part is" (NP4, p. 15). If registered nurses could not clearly differentiate their role, particularly from that of the LPN, it was her view that if proposed changes to LPN regulations were approved by government, LPNs would then assume a role similar to the RN and at less cost to the employer. As she described it:

> If they [AVC] prepared them [LPN] to do those activities, they would be competing with nurses. Now, in the big picture, why would any taxpayer, government, or public support programming that provides two types of workers to do exactly the same thing. It doesn't make any sense. On one hand the taxpayer may say, "Well, gee, if they can prepare that person in two years to do those activities, that's a lot better for me because my health care isn't going to cost as much, and the employer won't have to spend as much to provide the health care, so it's a good deal." (NP4, p. 19-20)

However, this argument, she believed, was "shallow" and out of step with current research.

> If we're talking about saving tax dollars, if we're talking about efficient use of resources, if we're talking about decreasing the funding of the health care system, the way to do it is to better utilize the registered nurse and, as we've argued for ages, stop this nonsense of start-up programs . . . to prepare people to mimic some aspect of what the registered nurse does. (NP4, p. 20)

Another interviewee felt that eliminating the exclusive scope of practice would lead to "incredible confusion about who is permitted to do what." However, she felt that the "down loading" of functions would reach beyond the LPNs, and that the unregulated personal care attendants would be asked to assume more tasks as well (NP1, 16). In noting the apparent inconsistencies in the manpower resources in relation to the acuity level of patients, she made the following comments:

> The technology that exists, the drugs that we use, the ability to sustain life and return people to function is far more complex, than it was . . . twenty years go. So the acuity and complexity has gone up, and at the same time, because of the financial pressures being exerted on the system, the withdrawal of massive resources, the number of staff as well as the skill level of that staff has continued to go down. (NP1, p. 17)

A variation on this same viewpoint was described by another interviewee. In her view attempts at using lesser skilled workers in high intensity, acute care areas had not been successful and the transition, largely spearheaded by an American consulting firm, had been costly and misleading (NP7, p. 14).

A spokesperson for one of the nursing unions expressed mixed feelings on what eliminating the scope of practice would have on nursing practice in general. She, like other interviewees, also related the change in nursing legislation to the changes in role enhancement in the LPN regulations. However, she was more reserved about what the change would actually mean for the LPN and how quickly a change in role would be evident. Furthermore, any enhancement to the LPN role she felt had to be considered in relation to other circumstances, including the history of previous regulatory change, current circumstances within the managerial component of the workplace and the responses of LPNs to the proposed changes. In discussing the potential for LPNs to assume a greater part of the registered nurse role, she stated:

> I would suggest to you that in the short term I'm not sure we'll see a lot of change immediately in terms of the LPN role. I think in some settings it will, but if you think back in terms of the changes that occurred around the scope of practice with medication administration, very, very few facilities actually implemented that. (NP1, p. 19)

However, she felt the trend toward non-nursing patient care managers could accelerate the use of less skilled workers since the previous advocacy role of unit supervisors had changed. In describing the current managerial roles, it was her view those who opposed the "transformation" had been removed and replaced with a non-nurse who was unlikely to be an advocate for nursing. The effect of this change she felt could result in "quicker embracing of these changes" (NP1, p. 19).

> What may make it significantly different this time is that the system is almost devoid of nursing advocates. If you look at what happened with the change in scope of practice before where LPNs could dispense medications, we had very strong nursing voices in the system. We had directors of nursing, and they were registered nurses. We had head nurses and nursing unit supervisors. Although the legislation permitted it, decision makers for nursing said, "Even though it's a permissible activity, we believe that, as a professional judgment, the more appropriate person to do this is still the registered nurse. We've lost that advocacy within [the system]." (NP1, p. 20)

Throughout the discussion on the meaning of eliminating the exclusive scope of practice, the assumption of each of the interviewees was that this change was a much anticipated opportunity for LPNs to assume a broader scope of practice. As one interviewee described it, the role looked much like that of a "nurse with a diploma, . . . all the hands-on kind of things, . . . and much more independence than they ever had before" (NP4, p. 34). However, according to one interviewee this was a faulty assumption. It was her knowledge that the changes in regulations proposed by the PCLPN was not supported by all of the membership (NP1, p. 19). As a manager in a long-term care facility described it, her LPN staff were not willing to assume more responsibility for the same salary.

> There's going to be a very few LPNs who will do this. There is, I understand, a great deal of reluctance on the part of many LPNs to do this [assume more responsibility]. I understand they're very opposed to their professional association's activities. . . . They don't feel they have the background, skill, and ability to do it, nor do they want that responsibility. "If I wanted that responsibility, I would have become a registered nurse." (NP1, p. 19)

Irrespective of whether LPNs were supportive of an expanded role, this same interviewee had a clear but personally troubling vision of what she perceived to be the future role for RNs. Part of this vision related to her observation that registered nurses were gradually being removed from the bedside as the provider of "hands-on care" (NP1, p. 22).

> There is potential that there will be very, very few registered nurses in the overall health-care system. I've heard for the last five years that the PCLPN has been talking about a two-year program, and the scenarios could go like this: RNs are baccalaureate prepared: LPNs become a two year program. Approximately seventy-five percent of the registered-nurse workforce that is nonbaccalaureate prepared, . . . they become quasi-LPNs? You end up with a system that has very, few registered nurses. They are there as overseers, supervisory to a workforce perhaps of LPNs and large numbers of PCAs. (NP1, p. 23)

The changing role of the RN, which she did not agree with, was brought to her attention at a conference she had attended.

> I used the term *staff nurse*—I think it's very wonderful. I was asked by somebody *not* to use that term: We're not a staff nurse; we're a patient care coordinator, which immediately implied to me somebody removed from the bedside, . . . and you're just coordinating everybody else's touching, and actual delivery of care. It was sort of the suggestion that the

> role of the registered nurse is not a direct relationship but a coordinator. (NP1, p. 23)

Another interviewee expressed the same concern that the elimination of the nursing exclusive scope of practice would facilitate the use of LPNs as direct care providers, leaving registered nurses in a coordinating role. From her discussions with nurses throughout the province, she felt staff nurses did not support this role (NP7, p. 19). In speaking on behalf of herself and the staff nurses with whom she worked, she said,

> We do not want to be removed from the bedside. Certainly, there are a number of things that we can have other care providers do for us, but I need to be seeing the patient and dealing with the patient in order to coordinate the care. It is not sitting in an office shuffling paper. . . . It's my interaction with the patient, my hands-on assessment that makes me a good coordinator. (NP7, p. 19)

This same interviewee felt that removing the exclusive scope of practice would not necessarily remove barriers between the traditional professional groups. She questioned the benefit of such a policy change, admitting that in her own mind she did not have a clear picture of future professional roles. What was evident to her was that discussion about barriers between professions was a function of the level of intervention.

> If we're talking about a practice setting and the various levels where the teams have to come together, I think they work really well. But, if we are talking about a policy level where the professions have to get together to make some decisions about who is going to do what, I think we do still have a lot of turf wars that go on. I think that actually it could lead to a lot more controversy between the professions, and for what? (NP7, p. 13)

She was less certain of what the future held for registered nurses with the elimination of the exclusive scope of practice.

> I still haven't gotten a grasp on it. After being involved with this since 1994, even to this day, I don't have this concept of what we're going to look like . . . when we're finished with this. What good is legislation

> change just for the sake of change? To me that's far too costly for everybody unless it's going to improve things. (NP7, p. 13)

Another interviewee voiced her concern about the impact of eliminating the exclusive scope of practice would have on nursing, although her concerns were directed at community services.

> I can't believe that there wasn't some vision that by changing some of what existed it would open the door for what in fact is happening, which is the introduction of less-qualified people into the health care system. We've also, at the same time moved more care into the community. . . . And so, there's the potential for less-qualified people to be working very independently with minimal supervision. I'm concerned with the changes that are being made to the legislation . . . because if you're not controlling what people do . . . as we move into a noninstitutional mode, I think the public is even more at risk than they've ever been. (NP2, p. 14)

This same interviewee was one of the few who referred to the proposed 'restricted activities.' She was not convinced that removing the exclusive scope of practice would remove the barriers between the professions, nor would the proposed legislation designating restricted acts "capture the essence of what the practice is" (NP2, p. 11).

> What it says to me is that as long as I don't do those [restricted acts], I can still practice medicine, I can still practice nursing, as long as I don't call myself a registered nurse. I don't think that addresses the issue that I thought we were dealing with, which was controlling and assuring the public that they were being looked after by competent people. I think the idea of moving away from exclusive scope of practice to more generalized, overlapping scopes, doesn't really concern me. But I'm not sure we've fixed the problem. (NP2, p. 11)

The problem, in her view, was trying to determine who was competent to perform specific skills and mandatory registration was unlikely to fulfill that objective. In further discussion with the same interviewee, it was clear that "fixing the problem" did not include replacing exclusive scope of practice with mandatory registration. "Mandatory registration will control who can purport to be a registered nurse. But it doesn't control who does nursing acts" (NP2, p. 12). In referring to the use of LPNs and PCAs, it was her view that the performance of a task was only part of a more complex process. "Does the person have sufficient knowledge, not just to do the task, but what to look at, the implications of that task in a broad sense?" (NP2, p. 13). Another interviewee was hopeful that the elimination of exclusive scopes of practice would heighten the need to monitor member competence. "None of the professions have done [this] very well. It's not just nurses; everybody" (NP5, p. 31).

In a related discussion of standards of practice, another interviewee felt that with the opening of the health profession acts, the AARN could have an opportunity to take a more active role in "ensuring that our practice standards and our code of ethics will give nurses the tools that have some teeth in them" (NP7, p. 12). In her view, nurses would then be able to say to employers, "This is the standard of practice. As an employer you have an obligation and I have an obligation and the setting has an obligation for me to be able to provide this" (NP7, p. 12). In her view, the Association had little authority over employment areas: "Essentially they [employers] can hire whom they want, and while we are saying we are protecting the public, the only control we have over that is the individual practitioner, who also has no control over the environment" (NP7, p. 12). If standards of practice were included in the regulations, she felt the Association would have more authority, or at least influence over what occurs in the work place.

One interviewee felt that eliminating the exclusive scope of practice may provide nurses with opportunities not previously available. In her view, although there were still restrictions on service delivery in the *Public Health Act* and the *Hospitals Act*, nurses would be able to practice to the "full extent of their scope of practice" (NP4, p. 34). The amendments to the Public Health Act allowing for nurse practitioners to be utilized in remote areas was one such example.

> It's a good way to go [eliminating the exclusive scope of practice] if you're looking at expanding or working to the full extent of the scope of practice of nursing. It's an opportunity to redefine ourselves . . . in a broader sense. I think for the most part nursing has an opportunity and should take it, just as other professions have an opportunity and should take it. (NP5, p. 36)

Also optimistic that changes to health profession legislation could produce positive results, another interviewee expressed her view that "without some external prodding, we'd probably just carry on discussing a lot of the same kinds of issues that we have discussed for years" (NP6, p. 16).

Potential Resolution of the Issue

The question of whether barriers to service delivery could be reduced or eliminated with the proposed legislation changes provided an opportunity for interviewees to express a variety of viewpoints. Some were explicit, others were philosophical, yet each contributed to a collective view of reservation, if not scepticism.

One of the interviewees representing the view of the AARN did not believe that eliminating the exclusive scope of practice from the *Nursing Profession Act* was necessary. Her view was that the premises on which proposed changes were based were not sound, though they reflected the view of a wider, but uninformed population. She also did not accept what she felt was a belief that professional groups restricted the practice of other providers.

> I think that it's a matter of clarity, of understanding. The AARN or any other professional organization does not need to be dismantled to achieve a free, open market. They can co-exist and still have a greater role in protection of the public safety in receiving nursing care without impinging on that free market. (NP3, p. 24)

In discussing 'turf' struggles between professions, another interviewee was sceptical about the future, particularly as an outcome of legislative changes.

> I guess the turf wars, . . . I don't know truly if we're ever going to really eliminate them. I think that if we can try to work in harmony and respect each other's roles, that we'll go a lot further in accomplishing this than we will by making changes to the legislation, because I think making the changes to the legislation just make us a bit more suspicious of each other as we look to see who's attempting to grab what. (NP7, p. 16)

Several interviewees were sceptical that placing restrictions on designated activities would be more effective in protecting the public than would the effect of exclusive practice. One interviewee felt that many of the professions held this view and that what was being implemented to control unregulated workers was a "ridiculous concept" (NP3, p. 25). In her view, the use of restricted activities was

> not the right mechanism to achieve [public] protection. As soon as you try to list any set of acts or tasks . . . it's immediately outdated. It's always controversial and contentious. It builds rather than reduces turf protection. Individual professions want to have one of the controlled acts for prestige, for goodness sake! Regulation is there to protect the public, it's not there to provide anybody with prestige. (NP3, p. 25)

Another interviewee felt that removing the exclusive scope of practice eliminated a comprehensive means to exclude individuals who were not competent to provide services. Restricting the performance of a few activities to designated professionals left a wide range of activities which could be performed without the necessary knowledge and skill.

> We've identified a few very key things that are still what we might call exclusive but there is such a huge area . . . that people who are not competent can do. If we go with the new legislation, as long as I don't do those things that are still exclusive, I can do a great deal of what can be considered nursing practice by simply not calling myself an RN, and there's no guarantee that I will be competent. We've created more opportunities for people who are not controlled to be giving health care to the public, who I don't believe have the knowledge and information they need. (NP2, p. 18)

Many of the interviewees felt that the barrier to the provision of non-medical services was more directly related to payment for service rather than any inherent restrictions in regulatory legislation. One interviewee noted that patients were already able to have direct access to nurses but were prevented from doing so because "the funding wasn't there" (NP4, p. 23). In her view, the underlying reasons for lack of funding were political rather than legislative.

> That's not legislation; that's a political barrier. The values and attitudes to make that happen are not there. . . . It has to do with what kept the ship stable, . . . and in most cases those were political decisions; nothing to do with scope of practice, period. That's not legislation or exclusive scope or anything else. (NP4, p. 23)

Rather than legislative changes, this interviewee believed that the utilization of nurses was much more dependent on the political will of government to fund nursing services and the political will of institutions to either remove restrictive policies or put policies in place which allow full utilization of nursing services (NP4, p. 24). In concurring with this view, another interviewee stated that until everyone was "paid out of the same pot," barriers between professions would continue to exist (NP6, p. 21). In her view, changing legislation was of doubtful merit in promoting integrated health services. Both of these interviewees referred to a recent amendment which allowed nurses to provide extended services (services considered to be outside the nursing scope of practice). In referring to the two conditions attached to this service provision, i.e., remote location and ministerial approval, one of the interviewees questioned the intent of the process:

> Why do we have those two barriers of setting [remote places] and ministerial approval? Again, that has nothing to do with legislation or whether nurses can be fully utilized. Those two statements are purely political, in my opinion, and they're barriers to fully utilizing nursing, irrespective of whether there is an exclusive scope for anybody. (NP4, p. 24)

In resolving barriers between professional groups, several interviewees referred to the need for interdisciplinary cooperation and collaboration. However, as one interviewee stated it, "I think it's very difficult to legislate greater cooperation" (NP6, p. 16). The perspective of another interviewee was that "you can't legislate working together because there's still too much turf out there" (NP5, p. 39). Collaboration between professionals was closely linked to the hierarchical level at which the interchange occurred. Much greater collaboration was apparent at the individual practitioner and team level than at an Association level: "There's good collaboration on the team that would be looking after you or me, but where there isn't good collaboration, and where I think it would be very difficult to get [is at the Association level]" (NP5, p. 39). In summarizing her views of the impact of legislative changes on barriers between professions, her prediction was that

> I don't think it's going to change a whole lot very fast. And, honestly, I think we've put too much stock in this professional legislation as being the panacea, because it isn't. What you can't change or legislate is all of those built-in attitudes, the politics, all of those other relationships that go on all the time between professional groups. . . . There were definitely some professions more influential than others, and even that won't change under this [new legislation]. (NP5, p. 39-40)

Other Policy Solutions

The final portion of the interview focused on two questions: What other policy solutions would be more effective in resolving the barriers between professions? and, What factors would affect the resolution of this issue? With the exception of overall support for a policy which retained mandatory registration, none of the interviewees offered alternate policy solutions. However, what ensued was what could be described as a philosophical and emotional discussion encapsulating a theme of 'where do we go from here,' assuming, as did many of the interviewees, that the proposed legislation was likely to proceed. The futuristic nature of the discussion was again premised on the fundamental beliefs of what had become the symbolic meaning attached to the nursing exclusive scope of practice. Each interviewee acknowledged that although the symbolism outranked the reality, exclusive scope of practice had come to signify three important conditions: the ultimate recognition of nursing as a profession, the means by which the public was protected from unsafe practice, and the gatekeeping process by which those not qualified were excluded from admission. In responding to the two questions, it appeared that each of the respondents mentally reconfigured the questions as if to ask, "How can we as nurses survive within the proposed context, having lost that which has, up to now, defined us as a profession and allowed for an unchallenged position within the health workforce?"

The direction of the discussion was best captured by the comments of one of the interviewees.

> Once we realized there was no argument on exclusive scope of practice, it was a done deal: forget it. We weren't going to be revisiting that, so we had to think of other ways. So, I believe the professions in general were influential in getting the Health Workforce Rebalancing Committee to make that recommendation about mandatory registration, and of course everybody will benefit from that, I guess, and I hope the public will benefit from it too. (NP5, p. 43)

In predicting a future direction, this same interviewee felt that the substance of forthcoming negotiations would need to encompass a balance between a strong regulatory system and means of ensuring professional competence.

> We're not going to focus on exclusive scope of practice any more because it's gone. I think what the professions will do now is look at all of those other recommendations that the Workforce Rebalancing Committee has made and see what kind of positions we might take on those recommendations when we get into real negotiations. . . . How can we have the strongest regulatory system possible to protect the public while making it administrable by self-regulating groups. The College of Physicians and Surgeons has instigated a Practice Review Program which is their way of looking at the continuing competence of physicians, . . . so I think that's were the focus is going to be. (NP5, p. 44)

Two other interviewees focused on the future of nursing as a profession without any direct reference to how eliminating the exclusive scope of practice might be an influencing factor. Based on meetings with nurses throughout the province, one interviewee referred to "the desire on the part of younger nurses to move ahead a little quicker," which she interpreted to mean that nursing as a profession wished to be looked upon as a "partnering profession as opposed to the same old handmaiden role" (NP7, p. 17). In referring to "new models" of health care delivery, she recounted the circumstances that nurses described to her.

> When they [professional groups] come through with new models, the pharmacists say, "We are wanting to provide a clinical pharmacy base now, . . . and we're going to have the RTs up here, . . . and we're going to have the physios up here, . . . and the physicians and the nurses." But by seven o'clock in the evening they don't want to be there, only nursing. And yet instead of nursing being looked upon as the senior profession that holds it together, they don't feel that way. Our young nurses are saying, "We need to take hold of that. We are the senior profession that holds this together." (NP7, p. 18)

A similar theme was described by another interviewee who felt nurses needed to be more aggressive in defining their role, particularly in relation to LPNs: "Their [LPNs'] job will be the direct care providers, and unless nurses, RNs, stand up and say, 'That's our job; we are woven together to do that job,' we're going to lose it. I really do think that" (NP1, p. 24).

This same interviewee, with a number of years' experience in a nursing union, was concerned with pending changes in professional legislation, but was much more vocal about what she perceived to be the broader concerns of staff nurses throughout the province. In speaking on behalf of unionized nurses, it was her opinion that the LPN group had advanced in the service sector because of internal struggles within the AARN, and a sense of uncertainty amongst the majority of staff nurses about who the Association represented.

> It comes back to some real problems, which I believe the PCLPN has been able to put to their advantage; of feelings of alienation and nonsupport from their own professional body. I'm speaking here in terms of staff nurses feeling disenfranchised and alienated by the professional association. (NP1, p. 25)

Accentuating the concerns of the "average staff nurse" was the promotion of baccalaureate education by the Association.

> The whole EP 2000 caused a lot of angst in terms of perhaps pitting our professional body against the membership. Maybe it was the way it was said more than what was said, . . . but staff nurses, eighty-five percent of them at the time were not baccalaureate prepared, and it was sort of a suggestion that they weren't as good. (NP1, p. 25)

More recently, in her view, the staff nurses were angered over what they perceived as attention being deflected from pressing health care issues.

> When Klein started all of these massive cuts, and the priority of the professional association was direct access, our membership was saying, "What are they [the Association] doing to help us defend the workplace? What are they doing to help us defend patient care and quality of care?" Direct access? That's just feeding into the privatization. (NP1, p. 26)

Her perception of the response of staff nurses to this direction was one of

> incredible anger towards the professional association from staff nurses that the profession in their most critical hour of need abandoned them and took up this initiative, direct access, that's going to benefit a very small, elite, highly educated group in our nineteen thousand membership, rather than doing anything to speak out about what was really happening to the thousands . . . and to patients. (NP1, p. 26)

In concluding her remarks, it was her view that "the AARN has major work to reconnect and know that they're representing the interests of the average registered nurse" (NP1, p. 26).

In responding to the implication of the proposed legislation, another interviewee expressed her concerns from an educational perspective: how to better define the role of nursing to students, and once they graduate, how to ensure competence. If greater evidence of overlapping professional practice was to be one of the outcomes, the challenge she saw was trying to define what nurses do amidst "the gray areas" (NP2, p. 21). In projecting shifts in the current education system, she was cognizant of the need for a re-direction in focus to encompass greater acceptance of overlapping professional roles.

> It tells me that we'd better do something in terms of interdisciplinary education as well. In talking about overlapping roles, then maybe we have to learn about that in our basic programs, not be isolationist in the programs, and then turn out practitioners and say, "Okay, now everybody is one big, happy family." (NP2, p. 21)

In relation to the possible shift to a less skilled workforce within nursing, this interviewee did not believe that the proposed legislative changes would promote such a transition. "I don't think the legislation is going to dictate that; I think that's going to be dictated by budgets and by decisions that are made in boardrooms" (NP2, p. 21). For her, what was important in a changing workforce was the need to maintain competent practitioners. "What nursing will have to do is to continue to ensure that idea of competence" (NP2, p. 21).

For another interviewee, the idea of alternate policy solutions was also very peripheral to what she believed was important to the future of the nursing group. She also felt that maintaining a competent workforce in all of the professions was the critical factor which she predicted would become the central force in protecting the public and replacing exclusive scopes of practice "which didn't work" (NP4, p. 21).

> That's the bottom line. How do we know the people that are out there are competent to do what they're supposed to be doing, rather than putting in place something that never could be enforced, was a bit inaccurate, didn't work. (NP4, p. 21)

It was also her prediction that eliminating the nursing exclusive scope of practice would facilitate more infringement by others because the scope of practice for nursing is so "broad, generic, ambiguous, unclear, and nonspecific." However, the 'solution' was not in creating more policy statements or maintaining exclusive legislation. "Exclusive scope isn't going to do it, hasn't done it, won't do it in the future" (NP4, p. 29). What was necessary to maintain the nursing profession prompted an impassioned 'address' as to what she believed were the key factors in resolving barriers, particularly within the nursing group. Her views reflected those of other interviewees, but were more directly and succinctly stated. They deserve to be quoted at some length:

> What's going to make nursing stand on its own, provide a service that is safe for the public, that the public wants to purchase, that the employers want to purchase, is going to be for nursing to provide good, competent, professional, economic nursing services to the Regional Health Authorities, . . . so that the regions have no other alternative but to purchase nursing services. And, if the service that registered nurses provide within their scope are not better in the long run, both in quality and economically, than the service of an assistant off the street who's got a six-week training course or an LPN who comes out of a one-year program, then there is no need for the services of registered nurses, and there's no need for the profession of nursing. Nursing has to prove . . . it has the political will, the commitment, to continually bombard those regions with proof, day by day, hour by hour, minute by minute, that they [regions] cannot find a better bang for their buck than a registered nurse, and that's what is going to do it, not exclusive scope. That's the bottom line. And if nursing can't do it, it's gone. The LPN [who is assuming a role similar to the diploma nurse] will be what the system will retain. (NP4, p. 30)

SUMMARY OF FINDINGS FROM NURSING RESPONDENTS

All respondents described the nursing exclusive scope of practice legislation as an important development in the professionalization of nursing as a discipline. Several interviewees described a sense of pride in having achieved exclusive legislation. This legislation, enacted in 1984, was significant in that the original objective of obtaining mandatory registration was achieved, along with the companion clause defining an exclusive nursing practice area. In describing the wording of the exclusive clause, interviewees felt the first two of the three statements were broad, general and generic, in many respects reflecting the perennial difficulties the nursing discipline had encountered in attempting to define that which distinguished the profession from other related groups. The third statement included in the exclusive practice area which referred to the administration of medication became problematic and was deleted as a restricted nursing function in 1987.

The interpretation of the nursing exclusive scope of practice was characterized by generic terminology making it somewhat unique in relation to other exclusive professional groups. All of the interviewees agreed that the intent of the nursing legislation was to acknowledge the discipline of nursing as a profession rather than as a significant means to exclude other practitioners. Interviewees described three characteristics of the exclusive nursing clause which lent specific support, particularly to their view that the legislation was non-restrictive of other disciplines. These characteristics included reference to the application of nursing knowledge, exemptions present in legislation governing other professions, and the legally indefensible nature of the exclusive clause.

Although the relationship between the nursing profession and other traditional groups relative to exclusive practice areas was reported as an amiable one, the relationship with the LPNs was one of repeated challenges and misinterpretations of legislation. While the exclusive nursing legislation provided the desirable perception that LPNs would be restricted from encroaching on the role of the registered nurse role, in fact, LPNs were legally exempt from the Nursing Profession Act and continued to expand their practice area to include tasks, i.e., administration of medications, traditionally assumed to be part of the registered nurse's role. The ongoing jurisdictional disputes between these two groups was frequently returned to in discussions related to proposed legislation changes and alternate policy solutions.

All of the interviewees felt that the proposed changes to health profession legislation had been crafted by government policy-makers. It was their belief that the primary impetus for change was the need by government to reduce the costs of health care by means of reallocating the utilization of manpower. Interviewees linked this rationale to what they believed to be a perception by policy-makers that professions, particularly those with exclusive practice areas, presented a restriction on the utilization of less costly but competent health care workers. Although these two interrelated factors were seen to be significant stimulants, other factors were also seen to be contributory: the need for greater public choice in services and providers; specific ideologies held by the Government of Alberta; changes in health legislation in other provinces, and the emergence of popular books on 'reinventing government.'

The majority of nursing respondents were not in agreement with the elimination of the nursing exclusive scope of practice, arguing that their legislation had not been restrictive of other disciplines. Interviewees substantiated their argument by referring to changes in the workplace which had occurred despite perceived restrictions in existing health profession legislation. However, the concerns went beyond changes in legislation, to include a sensitivity to the loss of nursing positions which had occurred in relation to changes in the health care system. In combination, these two events had translated into what interviewees described as a loss of professional identity.

There were diverging views as to whether the elimination of the nursing exclusive scope of practice would precipitate an increase in the utilization of LPNs. Two of the interviewees with experience in relation to nursing unions, and presumably with their 'finger on the pulse,' offered distinctly different perspectives. In general, most of the interviewees felt that an increase in the utilization of LPNs was unlikely, at least in hospitals, because of patient acuity. However, some interviewees claimed that staff nurses believed that with the change in legislation, they would be replaced by LPNs. This perception had resulted in pressure being applied to the Association 'to do something about it,' although interviewees felt such a role was not part of the mandate of the Association.

In addressing the research question pertaining to alternate policy solutions, all of the interviewees directed their comments at what they considered to be desirable future directions for the nursing profession. This diversion in discussion was based on several beliefs. First, there was clear indication from the majority of interviewees that there was no acceptable rationale to change the existing nursing legislation since it was not restrictive of other health professions. Second, it was felt that the proposed changes in legislation would not meet the objective of removing barriers between professional groups, since the barriers were largely attitudinal. Third, any changes in legislation relating to the provision of services were projected to be ineffective until payment structures reflected changes in service delivery. Fourth, there was a strong sense that the elimination of all exclusive scopes of practice was likely to proceed as proposed. And, finally, aside from the emotional attachment that had come to be associated with exclusive legislation, interviewees felt that in the final analysis, the elimination of the exclusive scope of practice would have little effect on the nursing profession. What interviewees felt was important for the profession was maintaining a competent nursing workforce and a more aggressive approach to presenting registered nurses as efficient and cost-effective providers of health services.

PERCEPTIONS OF A RESPONDENT REPRESENTING THE PROFESSIONAL COUNCIL OF LICENSED PRACTICAL NURSES

An interview was held with a representative of the Professional Council of Licensed Practical Nurses on April 8, 1997. The responses of this individual are reported according to the established data categories. In order to maintain the confidentiality of the interviewee, this individual is referred to as licensed practical nurse participant (LPNP).

History of the Exclusive Practice Clause

Interpretation of the Exclusive Scope of Practice for LPNs

The representative of the PCLPN indicated that overall the nursing exclusive scope of practice had little impact on LPNs. With the inclusion of the nursing assistants (later renamed licensed practical nurses) under the *Health Disciplines Act* in 1983, this group was exempt from the exclusive scope of practice clause as it applied to registered nurses. However, the desire to administer oral medication became an issue for both registered nurses and LPNs after the introduction of the exclusive nursing legislation. Although LPNs were exempt from this legislation, registered nurses were opposed to this group performing what was their 'flagship' exclusive practice. However, with the deletion of the clause from the *Nursing Practice Act* in 1987 the issue was resolved at least from a regulatory perspective. In describing the circumstances at the time, the interviewee stated:

> I think they [AARN] saw that there were some things . . . that would be a significant risk to the public. It was always our belief that the administration of medications was a part of that, and was included in there. However, there also was [a clause] . . . which talks about other legislation and that it does not apply to anyone who is covered under other legislation. So because we are covered by other legislation since we've been

> designated under the Health Disciplines Act we have never had any conception at all that it refers to LPNs. (LPNP, p. 1)

The Position of the PCLPN in Relation to the Exclusive Scope of Practice

It was the view of the interviewee that eliminating the nursing exclusive scope of practice would have "no effect" on the PCLPN in that their role was already defined under their own legislation (LPNP, p. 25). She also believed that the clause had served very little purpose for other groups, since it had never been used to inhibit non-nursing practitioners from carrying out nursing tasks. In speaking of the questionable utility of the legislation, she noted that

> if I have a reason for putting it there, and I don't tell you what that reason is or I don't share it with anybody else, and I never bother to implement the clause, then there's no point in it being there. (LPNP, p. 2)

However, in her view there had been opportunities for the AARN to utilize their exclusive legislation in preventing non-regulated workers from performing nursing functions.

> I don't know of anything that they [AARN] have ever done to enforce it. And I say that particularly in terms of the unregulated people, that they have gone ahead and done whatever employers have desired of them, sometimes with little or no training, and that there has never been anybody that has gone and challenged them under this legislation and said, "You shall not." (LPNP, p. 1)

In contrast to the unwillingness of the AARN to defend their exclusive practice area, she recalled instances wherein other professions readily challenged any jurisdictional transgression. In referring to practice disputes between physicians and mid-wives, she pointed out that

> when somebody has stepped on *their* [physicians'] territory they have immediately said, "Thou shalt not." They've been prepared to challenge it in the courts, which I think is the difference in what I have seen in this act

> [*Nursing Practice Act*] versus what some of the other professions have done. (LPNP, p. 3)

Eliminating the Exclusive Scope of Practice

According to this interviewee, the catalyst in changing existing legislation "has come from government. . . . I know that it has" (LPNP, p. 3). However, she also believed that this action had been influenced by employers, unhappy with what they perceived were restrictions on manpower utilization associated with current regulations. Professional groups had not pushed for any changes in her view; however, she was aware that "some wanted changes in their legislation" (LPNP, p. 4). She did not specify which groups or which changes she was alluding to.

Factors Influencing the Elimination of the Exclusive Scope of Practice

From the viewpoint of the interviewee, the proposed changes to health legislation were the reflection of a need by government to "bring some consistency to the way things are done . . . because all the professions have different rules" (LPNP, p. 4). The push for consistency, she believed, was in part being driven by national policies such as the Agreement on Internal Trade and the North America Free Trade Agreement both of which were examples of attempts to reduce barriers to registration between provincial jurisdictions. As a representative of a group who was satisfied with governance under umbrella legislation, she voiced her support for uniformity in legislation.

> We are not here for self-preservation; we are here to protect the public. And in my opinion, the change is necessary; it's a valid reason. There is no reason why processes for certain things, i.e., registration of the profession, discipline of the profession, and public access to the profession need to be any different for an RN, an LPN, a doctor, a dentist, or a chiropractor. It doesn't matter. If the disciplinary process is conducted in the same manner, anybody in the public knows that is what will happen. (LPNP, p. 4)

Another factor contributing to changes in legislation was the public perspective: "The public wants information, and they want to know where to go and how to get there. They don't want to have one rule that is different for everybody" (LPNP, p. 21). Nor did the public wish to be burdened by the interpretation of each exclusive clause for each profession. Consistency of legislation amongst health professions would therefore allow the public more meaningful, consistent, and user-friendly information when choosing health professionals: "It's certainly what the politicians are saying, that the public should have informed choices as to who they access in the system, which is another part of their rationale for eliminating the exclusive scope of practice" (LPNP, p. 5). The intent of government to have each of the professions describe in a brief statement in the new act "who we are and what we do" was an idea which she supported and one which she felt would enable the public to say, "That's the kind or person I need to see for this" (LPNP, p. 5).

Employers were also instrumental in bringing about proposed changes. In her view the perceived barriers to practice, thought to be associated with exclusive scopes of practice, was an argument which could not be disconnected from the earlier and popular notion of multiskilling which had captured the cost-conscious attention of employers at one time. Although the idea of 'generic workers' retained brief popularity because of vigorous opposition from "every health professional in this province," in the view of this interviewee, the idea was part of a collection of cost-saving ideas, including eliminating exclusive scopes of practice, which would "enable employers to have people that could do whatever they wanted with them" (LPNP, p. 6).

Expressed Positions of Stakeholders

This interviewee described what amounted to more and less legislation. In explaining the apparent contradiction, she stated that she supported the elimination of the nursing exclusive scope of practice, as well as similar legislation governing other professions. This proposed change, in her view, was an example of the stated intent of government to reduce the amount of legislation associated with health professions. However, although she supported this objective, there was another circumstance in which there was a need for more regulation: "When the government is talking about changing legislation and putting legislation in to govern the health care professionals, what they're looking at is people who are already regulated, and that's not the major problem" (LPNP, p. 7). In her view, the problem was the significantly large number of unregulated workers employed in the health system who were not governed by any legislation and therefore could be used at the discretion of employers, sometimes inappropriately. "We know that there are places where they are administering meds, they're doing trach care, they're doing dressing changes, they're doing catheterizations" (LPNP, p. 8). In describing the presence of this group, this interviewee stated:

> If you look at what has happened in the [health] industry in this province, the unregulated workers far exceed our [LPN] numbers now, and depending on whose quote you listen to about the number of registered nurses in the province, they're [unregulated workers] about three quarters of the way to the number of registered nurses. So obviously the utilization of those people is there. (LPNP, p. 7)

Although none of the nursing interviewees made reference to unregulated workers, this interviewee was concerned about their role, particularly since they 'bordered' the jurisdiction of the LPN. Her concern was focused on the relationship between untrained workers and public safety. In recalling events at various public forums on health care, she noted:

> I think it's been totally mishandled. The government has let the system do whatever they want to do. And if you look at risk to the public, I know the forums that I attended . . . that was the single biggest issue on the minds of the public who attended. . . . They were very concerned about these people who had little or no training; certainly no education, and some of them, very poor skills, and very limited language abilities. (LPNP, p. 7)

It was her view that the AARN would have been justified in using the exclusive practice clause to challenge the role of unregulated workers. The fact that the AARN chose not to take any formal action in the apparent contravention of their act was indicative of the symbolic status which she felt the legislation represented. As she described it, "The AARN never did anything. . . . They could have used the clause [exclusive scope of practice] in there to say, "That is nursing practice. . . ." In my opinion, all it was, was a status symbol" (LPNP, p. 12).

In discussing the reaction by registered nurses to the removal of the exclusive scope of practice from nursing legislation, it was her view that the AARN was opposed to such a change.

> I have heard AARN's presentations with reference to the whole business of changing the legislation, and the almost-verbatim comment that was made was, "There's nothing wrong with our legislation. It works well. It just needs a little bit of tinkering with." (LPNP, p. 13)

From the perspective of the PCLPN, the interviewee indicated that there was support for consistency amongst those professions governed under the Health Disciplines Act. However, she was aware this view was not supported by some of the free-standing groups.

> We [PCLPN] think it's a good idea to change it. We think that there are some rules that should be the same for every regulated profession; that there are some things that there is absolutely no reason why it should be different. Now, I do know that . . . they do not like the idea of having to change the way that they do their discipline process. We think that the process that we have under the Health Disciplines Act works very well. (LPNP, p. 14)

Alternative Policy Solutions

Factors Affecting Resolution of Barriers Between Professions

From the perspective of the interviewee, resolution of barriers between professional groups was not likely to be resolved by government directives. The key to resolution was dialogue and cooperation between the groups. The theme of her discussion suggested that alternative policy initiatives, particularly those generated by government, were not likely to stimulate much change from current practice. In her own words: "Unless there is the cooperation and a willingness to change by the people who are involved in the process, it's not going to matter what you do; barriers are still going to exist" (LPNP, p. 23).

The interviewee had been encouraged by an unprecedented request from the College of Physicians and Surgeons to meet with all the "players" regarding the proposed restricted acts.

> I have some positive feelings about going to this meeting . . . because they're going to bring all of the players together and say, "Let's talk about this." In the past, it has been government who has come and said, "This is what we want to talk about." This time it's being initiated by one of the professions with [invitations] to all of the rest of them. So maybe as a body we can come up with some solutions instead of being told what is going to happen. (LPNP, p. 24)

She believed that the emphasis on uniformity in the proposed legislation had promoted more inter-professional discussion than had been evident. One such example she described was a recently established multi-professional group to discuss disciplinary processes. The significance of such collaboration, in her view, went beyond the content of the discussion.

> I think the discussions are the key to it. I think that if there is open and honest dialogue, that's the key to it. Unfortunately, you don't always get that. People will say one thing at the meeting and then turn around and

> either say or do something else, or they come with their own agendas. (LPNP, p. 24)

Of all of the factors which were contributing to a reduction in the barriers between professional groups, she believed that a significant influence had to be credited to the personalities of those who had 'gone before.'

> If you look at the changes in roles and the changes in the system, the changes in responsibility, there is a far greater openness now than there was ten years ago. You're looking at a lot of players in the system. And then years ago probably everything was more physician dominated than it is now. And they still have a lot of power and a lot of control, but it's becoming shared, and it's being challenged more. . . . So, you're looking at a lot of different things here that have changed over the years. Put it down to personalities [named former prominent professionals]. (LPNP, p. 27)

In addition to the influence of key professionals over the years, she also attributed current circumstances to the unprecedented involvement of government. In years past, it was her observation that government had approved any reasonable request for legislative changes initiated by a professional group. In recent years, government had become much more concerned with the implications of these requests, and more attuned to the potential impact on neighbouring groups and the extent to which they upheld the singular objective of protecting the interests of the public. In describing the transition she stated,

> I don't think the government has ever taken such an active role in looking at legislation as what they have now. In the past, any profession who submitted a request for a change in legislation, . . . it was done. "Give me a valid reason for what you want," and it was done. The process to make change now is far more involved, [with] far greater stakeholder input. (LPNP, p. 29)

Possible Alternative Policy Solutions

The interviewee was unable to offer any specific policy alternatives; however, she was supportive of the need to replace exclusive scopes of practice clauses to better reflect the overlapping competencies which were apparent between the professions. The theme of her discussion seemed to suggest that well defined scopes of practice, with the acknowledgment of shared competencies, were more reflective of current practice, than continuing to perpetuate exclusive jurisdictions which to a large extent no longer existed in the manner previously known.

> When you are looking at health care and you're looking at nursing practice, there are a great deal of shared competencies. . . . So when you talk about the unique competencies, the unique competencies are based on education, and those kinds of things then would be defined in the scope of practice. There are many of the competencies that are shared by other professions, the ability to prescribe medications being one. (LPNP, p. 25)

Her conclusion was that legislative changes would be secondary to two other circumstances: professional motivation in bringing about greater teamwork amongst professions and a recognition of what regulation was necessary to protect the public and what was merely of symbolic importance to a particular profession. In returning to her earlier reference to a meeting called by the College of Physicians and Surgeons, she described the underlying intent of the request as an apparent new-found willingness to talk about mutual interests and to explore mutually satisfactory policy direction.

> The other thing that they are saying in their invitation is that because of the inclusion of restricted activities, there is a flurry of activity for professions or other unregulated groups to suddenly come forward and seek designation, because it is seen as—and that's their words—a status symbol, that is creating turf wars within the professions. If there were no restricted activities and each profession clearly had their role defined in their scope of practice, restricted activities would not be necessary. I think their concept has some merit, and I would like to listen to what they have to say. (LPNP, p. 18)

SUMMARY OF RESPONSE BY REPRESENTATIVE OF THE PROFESSIONAL COUNCIL OF LICENSED PRACTICAL NURSES

The representative of the Professional Council of Licensed Practical Nurses indicated that the nursing exclusive scope of practice had little impact on LPNs. Because this group was included under the *Health Disciplines Act* in 1983, they were exempt from the *Nursing Profession Act*. Despite this exemption, the desire of the Professional Council to include the administration of medications in their scope of practice was vigorously opposed by the AARN. However, the deletion of this clause from the exclusive nursing legislation resolved this issue, at least from a legislation perspective.

This interviewee believed that the nursing legislation had served very little purpose for the AARN. To her knowledge the legislation had never been utilized to challenge other disciplines, but more significantly, it had not been used to restrict non-regulated workers who this interviewee felt routinely violated the exclusive practice area of nursing. In the absence of any apparent utility, her conclusion was that the legislation was largely a professional status symbol.

The proposed changes to legislation were seen to have been initiated by government to provide consistency in professional governance, a policy direction which this interviewee supported. Consistent 'rules' for all professions were also seen to be favored by the public who were pressing for greater choice amongst providers. And, finally, employers were seen to be influencing legislation changes, particularly in facilitating the use of multi-skilled workers. While this notion enjoyed brief popularity, it later withered because of intense opposition from the professions.

This interviewee believed the AARN was opposed to the removal of the nursing exclusive scope of practice. She indicated that the groups who were governed under the Health Disciplines Act (including the LPNs) had been 'well served' by the uniformity present in that legislation and favored umbrella legislation. She suggested that some of the free-standing professions were not supportive of this particular model although she made no direct reference to the registered nurses. However, she was of the opinion that because the nursing exclusive scope of practice had *not* created barriers to the use of non-regulated workers, it should be eliminated.

From the perspective of this interviewee, the resolution of barriers between professional groups was not likely to be resolved by government directives. Unless there was greater cooperation between the groups, she felt there would be little change in the workplace. However, the increased involvement in legislation matters by government was, in her view, contributory to much more stakeholder involvement and greater attention to interdisciplinary implications of regulatory changes than had been the case in earlier times. In concluding her comments, she felt that the presently well-defined scopes of practice, with the acknowledgment of shared professional competencies, was more reflective of current practice, than continuing to perpetuate exclusive jurisdictions which, to a large extent, no longer existed in the manner previously known.

CHAPTER 6

PERSPECTIVES OF GOVERNMENT AND PUBLIC RESPONDENTS

This chapter provides a detailed description of the responses to interviews with three participants from the Department of Labour, the Department of Health and the Department of Advanced Education and Career Development and a detailed description of the responses to interviews conducted with three participants representing the public interest. The first section of this chapter provides a description of the responses to the interviews conducted with government representatives. A summary of these responses follows this section. The second section of the chapter provides the responses of the public participants followed by a summary of the responses.

PERCEPTIONS OF GOVERNMENT STAKEHOLDERS

This section is based on the responses to interviews conducted during May and June, 1997 with representatives of the Department of Health, The Department of Labor, and the Department of Advanced Education and Career Development. Interview data obtained from government participants are reported in relation to the main research questions: the history of the introduction of exclusive nursing scope of practice legislation, perceptions of the desirability and feasibility of eliminating the nursing exclusive scope of practice, and alternate models for removing barriers to practice between health professions. In order to maintain the confidentiality of respondents, government participants will be referred to as GP.

History of Exclusive Scope of Practice Legislation

The respondents from the three government departments all agreed that exclusive scope of practice had a long and 'checkered' past. As one interviewee described it, physician licensure is older than the province of Alberta itself. Long before Canada was thought of, debates between physicians and mid-wives were erupting in seventeenth-century England. Nevertheless, each interviewee underlined the view that current legislation, including the exclusive scopes of practice clauses, had been consistent with the era in which they originated. Their present stories, therefore, were really accounts of how those times had changed.

Promotion of Exclusive Scope of Practice Legislation

One of the interviewees stated that the stimulus for a nursing exclusive scope of practice came from the nursing association, and was part of an overall mission in the early 1970s to enhance the professional status of nursing. Characteristic of this period were the attempts by nurses to disengage themselves from what had been a traditionally subservient role to physicians.

> I think the AARN probably stimulated it the most. I think it had to do with job action in the '70s. There was a real push to have nurses paid more for what they were doing because they are central workers and they thought they were undervalued. . . . They tried to determine how they could bring their status up. . . . There was a strong perception that nurses were the helpers of doctors, and nurses wanted to change that to become colleagues . . . rather than the more subservient role. (GP2, p. 1)

However, nurses and physicians were no longer the only groups providing health services. They had been joined by a burgeoning array of other health care workers, most notably orderlies, attendants, nursing assistants, mental-deficiency nurses, psychiatric nurses, and rehabilitation practitioners, to name only those most closely aligned with nursing. As each claimed a niche in the health care arena, government was committed to "making sense of or stopping the clutter, to some extent" (GP2, p. 6). Exclusive scope of practice was seen as a viable solution "because when you define the boundaries, then all these other folks on the outside of the boundary don't fit any more" (GP2, p. 7). In explaining the government position, one interviewee stated,

> Rather than having a lot of people going around saying they could do things, there was a willingness of government to designate certain workers, so as long as a person was a member of that association in good standing, they were extended special rights to do that kind of work. Since doctors clearly had an exclusive scope of practice, nurses wanted desperately to have it. The government, I think, went along with it and actually quite vigorously pursued it. (GP2, p. 3)

There were other factors which promoted government cooperation. The training of nursing students was shifting from hospital-based apprenticeship programs under the auspices of the Department of Health to college-based nursing education programs accountable to the Department of Advanced Education. In describing the transition from a government perspective, an interviewee noted that

> the previous perception was that nurses were very kind, caring, wonderful people. Now they were being converted into more professional people, . . . and there was a move to create a more separate professional organization than was the case before. (GP2, p. 3)

With the responsibility for nursing education programs under the Department of Advanced Education it was an opportune time to re-examine curriculum. The conclusion of that exercise was that "if these are the things that nurses are taught . . . and can do, then why don't we put this into legislation?" (GP2, p. 3).

Not only was government in support of an exclusive scope of practice but employers had also seen the advantages to their staffing complements. In the late 1970s, an all RN-staff had become the trend in most large city hospitals. The message the government was hearing from these hospitals was that

> "we want fully competent and fully trained personnel. We don't want to have aides and LPNs because we've got enough money, we don't *have* to take them. Even if the nurse is just doing a lot of patient monitoring and bedside care, even if they're only using part of their skills, we're better off having a fully trained person because something might happen and we need

> them to do other things." So employers kind of liked the idea of exclusive scope too. (GP2, p. 5)

The 1970s had also been a period of labour unrest within the registered nursing group. As a result of this, there was a certain amount of public support for the registered nurses' position on nursing issues. Exclusive scope of practice seemed to provide the professional recognition that the Association was seeking. As a government spokesperson said, "I don't think the government was the instigator, but the government was a willing cooperator, because I think they accepted the idea, and wanted to do something more proactive about nursing" (GP2, p. 4). It was a time when government could be proactive; fiscal restraint had not yet become a predominating ideology and "they [nurses] had been knocking on the door with that kind of request [exclusive scope of practice] for a long time" (GP2, p. 5). In describing the government response, a spokesperson said:

> In government I think that's usually the way the game is played. The departments tend to be gatekeepers, and when they tend to agree that this is a good idea, then they open the gate. And so there was a willingness that had developed, almost a public consensus. There was a lot of money around in the late '70s and '80s. It sounded like a great idea to give nurses more money. You can't justify more money unless you can define what it is they do, and so exclusive scope of practice drew a boundary [around] what they did. . . . And so there was a general consensus that this was probably the way to go, and so it happened. (GP. p. 5)

Another spokesperson representing a different government department concurred that exclusive scope of practice was the policy direction reflective of the late 1970s (GP1, p. 3). At the time there were "two streams of policy legislation" (p. 1). There were those who were governed under the *Health Occupations Act* with non-exclusive right-to-title legislation. Other health professions were governed under a profession-specific, free-standing statute, all with right-to-title authority and some with exclusive practice jurisdictions. The distinction between the two forms of legislation was the risk of service provided, not the ability of the profession to provide its own regulation and govern its own members. However, as one interviewee pointed out, "It didn't make any logical sense" (GP1, p. 2). In recapping the circumstances at the time, her description of the introduction of the exclusive nursing legislation was a rather simple one: "The nurses had legislation before then; it was the Nursing Act before then. It needed to be revised. They wanted more modern legislation. And the way to do that was to bring in exclusive scopes of practice" (GP1, p. 4).

According to another interviewee, the model of legislation which professional groups wished to emulate was that which governed physicians, dentists, and lawyers and which provided for professional control over a jurisdiction. As it was described, "When the AARN worked on the *Nursing Profession Act*, they were striving to put legislation in place that probably replicated the other major professions" (GP3, p. 1). The implication of this model of legislation was that

> licensed practitioners would have the ability to provide the services of their profession to the public and nobody else could do that. . . . It served as a monopoly position for some of the senior professions in that the public didn't have a choice. I think it was protection to the public, but it also gave a sense of control for the professions that had exclusive scope. (GP3, p. 1)

Thus in keeping with other legislation, it was her belief that nursing felt that it was in their best interest to develop legislation to protect the application of professional nursing knowledge, being mindful of the registered nursing assistants who also performed a portion of nursing work.

> I think that what they saw was necessary because of the type of decision making and judgment that was required in the provision of those services. I think they were trying to look at what really needed to be exclusive to nurses and to make that a distinguishing factor. (GP3, p. 2)

The conclusion of two of the interviewees was that "the intent was good," (GP3, p. 2) and that "it made good sense at the time" (GP1, p. 7), but as more groups sought formal recognition, the number of professions with either exclusive scope of practice legislation or protected title had escalated to twenty-eight, and more were expected to make a similar request of government.

The issue of mandatory registration was an area of much less concern to government stakeholders than it was to the Association. In fact, the subject was referred to by only one of the three government interviewees. It was the belief of this interviewee that exclusive scope of practice compelled individuals to register if they wished to practice within the exclusive area. Because right-of-title was part of the exclusive legislation, in her view, it provided further restriction on non-registered persons. As she explained it,

> Exclusive scope of practice compels you to become a member of the AARN because the extent of your practice is clearly going to be nursing, and the only way you can do that is to be a member. Also bear in mind, there's also protection of title here. And so [that is] a very strong way of forcing you to join the profession. It's pretty hard to go out and practice as a graduate of a nursing program, practice in nursing, and not use the title. It's virtually impossible. (GP1, p. 4)

In her view exclusive scope of practice, not mandatory registration, was the important part of the legislative changes made to the nursing act in 1984.

> You will not find it [mandatory registration] discussed in the context of that legislation. There's nothing specifically that says you must register. The fact that you have exclusive scopes of practice *and* reserved titles makes it essential that you register in order to be a member of that profession. The term mandatory registration is only being introduced now once you've removed the exclusive scopes of practice. (GP1, p. 4)

Interpretation of the Nursing Exclusive Practice Clause

From a government perspective, the interpretation of the exclusive practice legislation was problematic. Although it was acknowledged that nursing legislation did not technically exclude other workers, there was a perception that it did. The phrase implied that a jurisdiction was exclusive. "It says there is only one group that can do this" (GP1, p. 7). And the nursing jurisdiction was broadly defined as was the historical case for physician legislation. Originally, as this interviewee recalled, "exclusive scope of practice wasn't even talked about; it was [called] a monopoly, and monopolies are very broad" (p. 8). The agreement with physicians was that "we [government] will give you control in exchange for something else" (p. 8). The requirement was that physicians would "govern their members in the public interest" (GP1, p. 8).

At a time when there were few alternatives for controlling the practice of medicine, the idea of physicians having a monopoly over care delivery in exchange for protection of the public interest was accepted by government, if not the public. "It was a very good deal" as this interviewee described it (GP1, p. 8). However, as times changed, exclusivity over a jurisdiction became less revered.

> Consumers were not very sophisticated. Medicine was essentially an "I'll take care of you" approach; very paternalistic. It was acceptable then. It's not acceptable to most consumers now. They do expect to have a better complaint process. And to be fair, this has been recognized in the professions, and changes in legislation have reflected this. People expect to have professions that are directly accountable. So, times have changed. There are a lot more professional groups around, a lot more overlap in function . . . and a more knowledgeable public. The system is much more complex now. (GP1, pp. 8-9)

Expressed Positions of Stakeholders

It was the view of at least two of the three interviewees that exclusive practice legislation had become an increasing problem for government with complaints about unnecessary restriction. They acknowledged that exclusive practice legislation did prevent unqualified individuals from "setting up shop to remove gallbladders or [do] things which were dangerous and require very advanced skill to perform" (GP3, p. 3). However, in their view, protected title offered similar protection to the public without necessitating the need for exemptions as professional practice increasingly overlapped the boundaries of neighbouring professions.

> It seems over the years that we have had more complaints to government that in general there's more restriction than necessary to protect the public. And so if you achieve what you want to do, which is ensure that services are provided by safe, competent, ethical practitioners with protected title, what is gained by having exclusive scope? (GP3, p. 3)

Therefore, in removing exclusive scope of practice, government felt a responsibility to determine some way

> to protect the public against those really dangerous services that do have long-term [implications] to ensure that those activities were identified and there was some way to protect the public from having unregulated people performing them. (GP3, p. 3)

Elimination of the Exclusive Scope of Practice

Each of the government interviewees had been involved with professional legislation for many years, with two of the interviewees having direct involvement with the drafting of exclusive legislation in the early 1980s. In addition, one of the interviewees had been a member of the Workforce Rebalancing Committee which had been instrumental in proposing the current proposed changes. Therefore, it was not surprising that each engaged in an extensive discussion of who was promoting the changes in legislation and why change was perceived to be necessary.

The interview schedule included a series of separate questions related to the elimination of the nursing exclusive scope of practice: Which stakeholders were promoting a need for change? Why was the nursing exclusive scope of practice clause being eliminated? What factors were contributing to the increased demand for change? and What were the expressed positions of stakeholders? However, each of the interviewees chose to combine the questions in a broad discussion, rather than responding to the ordered interview schedule. In reporting the findings, an attempt is made to group the responses according to the original schedule in order to bring some organization to what was a lengthy discussion, yet not lose the major themes and the interrelatedness of the factors or circumstances involved.

Promotion of a Need for Change

Each of the interviewees agreed that the primary force to change existing professional legislation was coming from employers and, secondarily, from the public. To a lesser extent, government was largely responding to the expressed positions of these stakeholders. None of the professional groups had expressed a need to change their own legislation although the nursing group maintained a long-held belief that the physician scope of practice was restrictive to the performance of an enhanced nursing role (GP3, p. 3).

Factors Contributing to Change in Legislation in the 1980s

The 'seeds of discontent' with professional legislation were evident long before the implementation of the Workforce Rebalancing Committee in 1994. One of the interviewees noted that a policy paper had been released in the early 1980s by what was then the Bureau of Professions and Occupations. The primary message was one of encouraging professions to be more transparent in the processes that were used by regulatory bodies for discipline, for handling complaints, for registration, and to assess competencies. In describing the government position at the time, one of the interviewees noted:

> There were clear statements made that there had to be more accountability on the role of the regulatory body to ensure the ongoing competency of their members and that there should be quality assurance processes built in. I think there was a clear direction given. (GP3, p. 4)

However, the forthcoming changes were not what was hoped for.

> I'm not sure that we saw a lot of change that was voluntary as a result of that policy statement. I think professions felt they did a good job, but basically they were weeding out bad apples as opposed to developing their individuals in their profession and holding them accountable for the knowledge and skill that was beyond their basic skill that they entered the profession with. (GP3, p. 5)

Although this circumstance was an early indication of concern with existing legislation, over the next ten to fifteen years changes in the workplace escalated the concerns. As one interviewee recalled, "It wasn't long after exclusive scope of practice was implemented that people said, 'Oh, my goodness, I think we went too far!'" (GP2, p. 7). Some of the first complaints about the nursing exclusive of practice came from the Department of Education, in defence of teachers giving medication to children during the school day. In trying to resolve this commonly occurring situation,

> there were long debates about how we can give permission to non-nurses to give medications. Secondarily, there became an awareness that these nurses are very expensive to have when it comes to giving a child medication. . . . So there began to be some grumbling about the exclusive scope going too far. (GP2, pp. 7-8)

Concerns voiced by the Department of Education were echoed by other professional groups, some of which reflected a lack of understanding of the legislation. Other groups were saying, "We've always been doing this and now we can't" (GP2, p. 8). As one interviewee described it,

> When the exclusive scope came in there wasn't much understanding that just because you've been doing it before, you have to stop now. And so it was only when there was some chafing that occurred that an issue would come up and they [other professions] would say, "Well, smart guys, you made these rules. Now how does this work? Do we have to bring a nurse in to do this ten-minute treatment?" So these were just little examples. (GP2, p. 8)

Also, as more care became delivered at home by a non-nurse health care worker or family member, one interviewee noted that "it became clearer and clearer that this was not a neat package" (GP2, p. 8). As on interviewee explained, the introduction of the exclusive scope of practice had been based on the premise that nursing, at the time, occurred in active treatment hospitals and nursing homes. As he noted,

> As long as the world didn't change, it would probably have been fairly manageable. But as the world [did] change and more and more people with disabilities were cared for at home and in community agencies, and other alternatives to traditional medicine began to develop, it became clearer that nurses couldn't do all of the things that are in their exclusive scope of practice. . . . There was a shortage of nurses. You couldn't hire enough nurses in those days, couldn't train enough. (GP2, p. 8)

The role of the LPN also became an issue during the 1980s. According to an interviewee, LPNs were becoming more popular with employers because they were less costly than an RN who seemed more suited to acute areas. A common staffing arrangement in extended care facilities was a large contingent of LPNs supervised by a few RNs. The LPNs were beginning to be vocal about their role and skill level. As one interviewee described the circumstances,

> While the activity [of an LPN] might be carried out under the implicit supervision of a nurse who might be down the hall or on call at the end of a telephone, in fact some of these things were exclusive scope of practice procedures. [LPNs were saying,] "We're doing it all the time, and most of the time I don't even do it under the supervision. So, why can't I do it." (GP2, p. 9)

In summarizing the government response to circumstances that were developing in the 1980s, this interviewee noted:

> It became clearer and clearer that exclusive scope of practice [wasn't] as exclusive and clean as the original planners thought it was. I don't think that it went much further than that at that stage. So there was discomfort,

> but I don't think they [AARN] ever went to the wall to punish people because they were touching their exclusive scope. It was just more of an irritation, or something that people could squabble about. (GP2, p. 10)

Factors Affecting Change in the 1990s

By the 1990s, each interviewee acknowledged that the "world began to change," and financial issues had become a much more prominent focus of discussion as had the locus of care delivery. As one interviewee described it, "I think the mood began to change, [and] the context began to change with the pressure on hospitals to live within tighter budgets" (GP2, p. 10).

Budgetary Reductions

All three government interviewees agreed that the primary motivation to change professional legislation came from employers who were experiencing unprecedented budgetary reductions. What had traditionally been a need-driven budgetary system shifted to a resource-driven process. According to one interviewee,

> The hands of administrators were being tied more tightly to manage with what you've got. Instead of saying, "Tell us what it costs to operate, . . . then we'll give you some more money to administrate." Now we're saying, "Here is ten million dollars. You run it with the same number of beds operating. You figure it out." (GP2, p. 12)

With administrators facing declining budgets, attention turned to the largest of expenditures, manpower, and the concomitant issue of effective utilization. One of the interviewees best described what became a recurring theme:

> I think that the primary motivation came from employers, and the big employers felt quite restricted in the ability to use a range of providers who seemed to have the competencies. And there was a concern that perhaps physicians could be better utilized in the system if other practitioners like nurses who had advanced practice skills could do more assessment of colds and coughs and flus, and leave the more complex secondary and tertiary-level services to the specialists. I think people were starting to question

> whether we were using people appropriately in the system and whether there were other practitioners who weren't being utilized to their fullest capacity, and the economics of that. If people could be trained and safe and could do more, then we shouldn't maybe have a physician as the gatekeeper and continue the gatekeeper role and perpetuate what has been. (GP3, p. 5)

The need for employers to have more flexibility in staffing was described by this interviewee as a "big, driving factor" (GP3, p. 8). Traditional staffing patterns were no longer considered appropriate in light of changes in physician practice styles, experience of staff, severity of illness, and location of service.

> I think the employers started to say, "We need some flexibility here. What might have been considered adequate staffing maybe isn't adequate any more. . . . You have to weigh so many factors and conditions here." So I think that they were looking for some flexibility to look at mix. (GP3, p. 8)

As pressures on hospital budgets continued administrators began to retreat from a position of not hiring LPNs to "welcoming them back" (GP2, p. 10). All-RN staffing "fell by the wayside" as the focus shifted to what staff could do rather then what they were called. In describing the shift in manpower utilization, one interviewee stated,

> They were looking to hire whoever could do the job. Employers were now saying, "Hey, maybe this [all-RN staffing] isn't as good as what we thought." It was a great idea if you have lots of money. . . . Then there was discussion about exclusive scope because you had people working together, LPNs working in ORs and . . . doing certain kinds of treatments. (p. 10)

According to the interviewees, employers became much more concerned with skills and tasks and legislated scopes of practice came to be seen as obstructive to staffing objectives. "Who could do it became less clear under the pressure of needing to have capable people" (GP2, p. 11). A typical statement that government was hearing from employers was, "If they've been through a lot of inservice training and they've got good experience, then they can do it as well as anybody else, so we'll accept that" (GP2, p. 11). However, as one interviewee intimated in referring to a paraprofessional group, there were concerns about the qualifications of those being hired: "There are concerns in the system, broad concerns about who is doing what . . . concerns about the qualifications of people being hired in the system, what kinds of controls are being exercised on these people" (GP1, p. 12).

However, as employers continued to be pressured by reduced budgets, there was growing disenchantment with exclusive jurisdictions. According to one interviewee, the challenge exceeded the evidence. "Exclusive scope of practice was less of a barrier than we were led to believe" (GP2, p. 20). In speaking specifically of the exclusive nursing legislation, he recalled that because nursing "didn't shoot anyone at the border," government had chosen to leave the legislation unchanged until it could be demonstrated that it was "not good for the public" (GP2, p. 20). However, as he described it, hospital administrators had come to view it as an irritant.

> It was written there so it was something to complain about. . . . There were a lot of what-if problems around it, but there weren't many clear cases where somebody was being harmed because the exclusive scope existed. I think that administrators have used this to some extent to say, "Let's get rid of the exclusive scope because it really isn't any help to us; it's a hindrance to us, in fact. We don't see that it's really any big advantage to the nursing group, except it's a feather in their hat; it's a flag flying." (GP2, p. 20)

Administrators of community services were also voicing their discontent with exclusive regulations, joined by the sympathetic voices of others.

> There were more rumblings about "exclusive scope isn't really helping any more. This is making it far more difficult." So once that started, I think, the other occupational groups chimed in and said, "Yes, you're right! We could help solve your problems if you could do something about this." (GP2, p. 12)

As the concerns of employers and professional associations were heard by the Alberta Health Workforce Rebalancing Committee as they embarked on their mandate in 1994, one of the members recalled the ideas which were circulating amongst the committee.

> Maybe we could change the way workers are prepared and the way that they're defined. . . . If we have some way to know that workers are capable and competent to do tasks, then they should be designated or labelled and they should do it, but they don't all have to come from a certain school. They don't all have to be engineers or nurses or doctors . . . because . . . very broad categories do not [reflect] the workplace in a way that makes it easy to coordinate and use people efficiently and effectively. So, that was the kind of arguments that came out. And in the . . . presentations there was eagerness on the part of some of the groups that wanted to see the boundaries change. (GP2, p. 13)

Perceived Shift in Nursing Role

Another factor inherent to the discussion about the nursing exclusive scope of practice was the perceived shift in practice relative to level of education. It was the perception of both the Department of Health and the Department of Advanced Education and Career Development ("and elsewhere") that nurses were moving away from bedside care, yet maintaining that "bedside care is [our] central area" (GP2, p. 14). This perception was rooted in the observation that

> there had been a period of five years of more of the AARN particularly pushing graduate education and PhD. So there'd been a lot of emphasis to say, "Nurses are not really handmaidens of physicians. . . . They do high-level things. They do research; they do counselling; they do supervision; they do management; they solve problems; they think deeply about things; they are not technicians." (GP2, p. 14)

The feeling was that most of the educational emphasis was directed at preparing nurses to work at "a higher level" than direct patient care (GP2, p. 14). The emphasis was seen to be "on problem solving, [and] changing and expanding the role and significance of nursing" (p. 14). It was with this perception that government representatives were listening to the licensed practical nurse group as they presented their persuasive view to the Alberta Workforce Rebalancing Committee.

> It wasn't seen as clamouring to hold onto some of the tasks that LPNs wanted to do. LPNs said, "No, we don't feel embarrassed about doing bedside care or baths and so on." They'd like to do it. So there was that kind of perception. And I think the LPNs have been very strategic and vigorous in their meeting with every minister that came along and the deputy ministers. . . . So, they've been doing their homework well. (GP2, p. 15)

The Need to Increase Access to Service Delivery

Another factor motivating the need to change existing legislation was the need to increase access to service delivery. Each of the interviewees referred to the shift away from the traditional role of physician as the gatekeeper of health services to the public preference for greater access to a variety of health services. In describing the desire to amend traditional practice, one of the interviewees stated:

> I think there was a shift in thinking, that perhaps we needed to move away from the physician as the primary care provider and the person who controlled entry into the system and a lot of resources that we used for illness care. Perhaps we should start looking at different entry points for people to access the system and to make appropriate use of a range of providers. (GP3, p. 5)

As this interviewee acknowledged, much of this thinking had been stimulated, at least in the mind of government, by questions surrounding the existing referral system, particularly in relation to nursing, dietitians, and physical therapists. Although physical therapists had recently been allowed to provide direct access service, questions remained. "Were there processes in place which were unnecessary? Was there duplication of tests and orders that would be unnecessary if we could use people in a more effective way?" (GP3, p. 5).

Others felt there was, in general, overregulation and unnecessary restrictions all pertaining to exclusivity within jurisdictions. According to one interviewee, "There were restrictions at all levels, in acts, in regulations, even in bylaws, and we needed to have a look at where they occurred" (GP3, p. 6). She used the Hospitals Act as an example of the legislated restrictions on who could engage in a hospital admission. It was this type of circumstance which the interviewee claimed had raised legitimate questions.

> Why shouldn't another practitioner who is capable of making assessments have admitting privileges, like chiropractors? And midwifery had also been a 'window of opportunity' because as we started to introduce midwives in Alberta, then we really [saw] where a lot of the barriers were—in bylaws, in acts, and in regulations under the Hospitals Act. (GP3, p. 6)

Not only were professional groups voicing concerns over restrictive practices, but well informed consumer groups who felt limited in their ability to choose qualified people had also entered the foray. As one interviewee described it:

> The public, too, was starting to say, "We are more sophisticated; we can discriminate more. We would like to take more responsibility for choosing a provider, as long as they meet certain qualifications. We would like to know that we might have a choice of going to a physical therapist, a chiropractor, or a physical therapist for a back problem. As long as we know we are going to competent people we would like to have the option." (GP3, p. 6)

With the transfer of responsibility for the delivery of health services to the Regional Health Authorities a number of changes had been made to related acts. As one of the interviewees pointed out, the changes in who could provide services affected nursing directly.

> If we hadn't worked on an amendment to the Public Health Act and worked with the College of Physicians and Surgeons and the Alberta Pharmaceutical Association, we would not have been able to give registered nurses [in advanced practice] the legal authority to diagnose,

> because diagnosis was exclusively within the medical domain. We wouldn't have been able to allow them to prescribe a lot of the drugs that are currently going to be prescribed by registered nurses in advanced practice. Those are the kinds of restrictions that occur when you have an exclusive scope of medicine. (GP3, p. 10)

In describing the intent of the government stakeholders to increase the access to service provision, the same interviewee also noted how the need for public safety had been included in the solution.

> The fact that a doctor can do spinal manipulation doesn't mean that that's an exclusive medical domain; [physical therapists] can also do manipulation. So we needed to . . . define what registered members of a profession can do. When we went to define scopes that were overlapping, we removed that exclusivity that's no longer there to protect turf. . . . Then we came up with the restricted activities list, and that is the thing that protects the public against unregulated people [providing] dangerous services. (GP3, p. 10)

Overlapping Scopes of Practice

One of the interviewees noted that there had been a evidence for some time that all the professions and related subsidiary groups had shown a history of "moving up" as they pursued advanced preparation commensurate with expanding roles (GP2, p. 15). Inevitably, as groups assumed additional functions their role overlapped with other professions.

> Basically there was a feeling that the categories were moving up. Nurses were going to be given more responsibility at the degree, master's and PhD level. . . . So that boosted the perceptions that LPNs will be the nurses of twenty or thirty years ago. The hospital administrators and others were pushing [for] on-the-job trained personal care aides, and there's a move to institutionalize that, so there'd be training programs for aides. I think Advanced Education worked very hard to see that that didn't happen, but probably in the end we will lose that battle. . . . Everyone else will be bumped up, . . . and before long the first layer will have a union. . . . It's an evolutionary thing, and while we'd like to think that it's driven mostly by reason and logic, I think there are powerful forces, . . . funding and lobby

> efforts. So you end up with a consensus from time to time as a statement of public policy. "This is how we play the game, right?" But it only holds for a while, and then it begins to soften. (GP2, pp. 15-16)

However, in speaking as a member of the Alberta Health Workforce Rebalancing Committee, he wished to point out that none of the professions had been "singled out" in relation to the elimination of an exclusive scope of practice: "It was just the environment, things were changing. The rules that we had before have problems; they should be up for review and possible change" (GP2, p. 15). Also acknowledging that overlapping scopes of practice had become very evident, another interviewee described the conflict with the basic premise of exclusivity this way:

> Today we were looking at the scope of practice for respiratory therapists, and it's changed so much now that in their advanced scope, under the supervision of physicians who are qualified and competent, they can assist with anaesthesia. I know registered nurses can too if they've taken advanced anesthesia courses. So you see how these overlap so much? How can you say anything is exclusive? (GP3, p. 18)

In projecting that scopes of practice in all professions would continue to change and expand, the conclusion was that competence would be more important than exclusivity. From the discussion, it was clear that any final policy statement would need to include accountability for continuing competence. Legislation had established entry level competence by means of a credential, but the "challenge" was going to be the maintenance of competence over time.

> One of the things that will be required of a College is that they will have to implement a continuing competency program, because in the past the emphasis has been on ensuring that there was a standard set by the association for entry into the practice of the profession. But to put the emphasis on continuing competency, this is going to be a major challenge for *all* the professions. (GP3, p. 18)

However, in acknowledging the importance of continuing competency, this same interviewee noted that "it's one thing to say on paper that competency assessment should be the cornerstone, but it will take a while. . . . I know all the associations are struggling." (GP3, p. 19)

Expressed Position of Stakeholders

The response to the elimination of the exclusive scope of practice varied in accordance with the overall agenda of professional groups. In speaking from the perspective of having read and heard all the presentations to the Alberta Health Workforce Rebalancing Committee, one of the members pointed out that not everyone was opposed to the legislation change.

> There was quite a lot of eagerness on the part of some groups that wanted to see the boundaries change . . . to see growth in their territory. And to some extent the exclusive scope of practice certainly didn't win any friends for doctors and nurses, because they were seen to have tied up their part of the territory, thank you very much. Instead of nurses having a lot of colleagues in this, they didn't have very many. They were seen to be on the defensive and suffering badly from the . . . layoffs, because they were devastated. . . . So, the early rounds of the health care rebalancing situation were not cheery times for nurses. (GP2, pp. 13-14)

On the other hand, according to this same interviewee,

> The LPNs [were] riding quite high. They were seen as being steady, capable, helpful workers, not strident like sometimes UNA and the Staff Nurses' Association are seen to be. So they were perceived in a much more positive light, I think, and a lot of people could see no good reason why they shouldn't be provided opportunities to do tasks that RNs generally feel are beneath their level of training. (GP2, p. 14)

Another interviewee described the nursing response to the legislative changes as "cautious," adding that recent changes in the workplace had been a contributing factor. In speaking of health care reform in general, she noted that, "It's affecting nurses in terms of their day-to-day jobs. And what can you say? We've got the same number of doctors we've always had" (GP1, p. 15). As attention was redirected from intense hospital-based systems to home care, nurses were "especially concerned in terms of deskilling." Her conclusion was that these concerns were somewhat justified in that "there are aspects of care that does not require the skills of a registered nurse" (GP1, p. 16). Thus, in the view of this interviewee, the response of the registered nurses was understandable.

> If you happen to be in the group that is being pushed out of it, you are going to make the argument for, "Hey, I have the qualifications. I am the best qualified to do this, yet you're bringing in the unqualified to do it." (GP1, p. 16)

In speaking of the response to changes in legislation, one of the interviewees emphasized that the government objective was to provide consistency amongst the twenty-nine health professions rather than confine the focus on particular interests. The intended outcome was to have the public understand "who is regulated and who is not, and when you are regulated you have protected title" (GP3, p. 11). In describing the government position, she stated,

> We want some consistency in how they're regulated and we want to understand what we're doing overall to promote minimum regulation that's necessary to protect the public, but at the same time provide maximum flexibility for employers, who can use competent people. We had to look at exclusive scope in the eight major statutes and say, "If we're not going to have exclusive scope because it does create barriers for some professions to do things that traditionally have been the doctors' purview, then how do we ensure that we can have people like midwives deliver babies, physicians deliver babies, and some RNs . . . deliver babies, and ensure that they're not practising medicine without a license?" (GP3, p. 11)

In referring to the increasing importance of the community-based team, she also pointed out that "we have to have autonomous professions that can work together, that respect each other's discipline. . . . That would never happen if you still have one provider who is primarily the gatekeeper" (GP3, p. 14).

During the process of changing the legislation, the Health Workforce Rebalancing Committee along with several government departments received written submissions outlining concerns of the professional groups. One of the interviewees noted that the AARN, UNA and the Staff Nurses Association of Alberta had all expressed concern about the changes proposed in the LPN regulations and the impact on public safety and liability of employers. They were also particularly concerned with retaining the supervision for clinical nursing services. In responding to the concerns, an interviewee stated,

> I don't think that the issues of liability have been brought forward by employers, so I think they feel comfortable that they have the authority and responsibility to determine the mix and to ensure that the providers are competent and that they provide effective service. So I think any time we see a group that can take on a fairly large component of the scope for a profession, that's threatening. (GP3, p. 24)

This same interviewee pointed out that the registered nurses were particularly adverse to the proposed schedule of restricted activities, contending that the complexity of professional practice could not be captured in a list of tasks. In describing the difficulty of attempting to establish a means to protect the public from dangerous practices, one interviewee noted:

> I guess the only thing that I would say is, we have heard a lot from the AARN about the various pieces of our proposed act, and while they may not always agree with what we're doing and how we do it, they do participate. And, for example, with our restricted activities, they've let us know that they don't like defining a list, and they've told us why. If we could figure out another way to do it, I guess we would, but we don't know how to do it differently, so we're staying the course on defining the list. . . . It will be reviewed in time, and as we live with our legislation, if it's proclaimed. Then we will probably get smart, and we will find out that

> the principles that guided us then may not be the principles that will guide us into the year 2000 and beyond. So I'd say it's dynamic. (GP3, p. 22)

In concluding a lengthy discussion on the government position on proposed changes, this same interviewee summarized what she saw as the response from the professions, particularly nursing:

> Some professions may feel it's punitive . . . that they've given up more than they have gained because they've worked so hard to develop their act, and they're so proud of it, and they feel it was working effectively. They feel they took the responsibility that was given to them [for self-governance]. But in the broader scheme, while we may have changed some things that work, to get that uniformity across, we have decided on this model. And I think most professions felt this was the proper way to go. (GP3, p. 12)

Alternate Solutions to Proposed Policy Changes

The last section of the interview schedule pertained to the feasibility of other policy solutions rather than eliminating exclusive practice legislation and the factors which would contribute to the reduction of barriers between professional groups. None of the interviewees suggested a significant policy direction from that which was already proposed and which they all felt would likely proceed in some form through a legislative process. With these introductory comments 'on the table,' each of the interviewees became more comfortable discussing their personal viewpoints As 'veterans with war stories,' each described their perceptions of the process that had been utilized to develop the legislation, the factors associated with the resolution of barriers between the professions, and their projections on the impact of legislative changes on the nursing profession.

How the Proposed Changes Came About

All of the interviewees felt that there had been ample opportunity for all of the professional groups to have input into the proposed changes. "That's one thing I don't really even need to defend" (GP3, p. 20). As another stated it, "The drafts really reflect the input from all of those groups" (GP1, p. 19). In describing the consultation process, one interviewee explained,

> We call them together and we'll further consult with them to understand their concern to see if there is another alternative or other options. We actually worked with about six health professions when we were just doing our initial drafts to tell us if we're on track. We didn't want to give preferential treatment to certain groups over others, but at the same time we needed a group to steer us. . . . Everybody gets their opportunity to review each section of the act as it's developed, and then of course it will go through all the government review process once it's tabled in legislation. I think that that's about as fair and as open a process as what we can commit to in government. (GP3, p. 21)

In the discussion, reference was made to similar legislation which had been implemented in Ontario. The position of government on patterning legislation after other provinces was clear from one interviewee. "The provinces do not overtly look to another province, particularly Ontario, but they are certainly aware of it; they know it's there" (GP1, p. 14). As one of the interviewees pointed out, Alberta had chosen to develop legislation that was appropriate to provincial circumstances.

> We are kind of adopting our own approach, even though we've looked at other legislation. We didn't just pick Ontario's model and say, "This will be Alberta's model for the future." We haven't adopted the BC approach either. Things are very different in BC than Alberta in terms of the deployment of health personnel. (GP3, p. 22)

Perspectives on the Elimination of the Nursing Exclusive Scope of Practice

The latter part of the interview was devoted to a discussion of how effective removing the exclusive scope of practice would be in reducing the existing barriers between professional groups, and in particular, how the nursing profession would be affected now and in the future. After initial attention to the impact of legislation, each of the interviewees described what they perceived as important in shaping the future direction of nursing.

Impact of Removing the Nursing Exclusive Scope of Practice

Two of the government interviewees viewed the elimination of the nursing exclusive scope of practice as having very little effect from the perspective of the workplace. The fact that changes pertaining to the allocation of manpower within the health system had occurred prior to changes in professional legislation was evidence of that reality.

> In truth, I don't think the exclusive scope of practice has had [much]impact on the practice of nursing as it is. . . . It's held over from the older system. But does it really restrict what nurses do in the system? Like I said, the changes have been developed with that exclusive scope of practice right in place. I think it's confusing; it leaves people to expect restrictions when there aren't any. (GP1, p. 25)

From the perspective of another interviewee, the impact was more likely to be felt by the nursing profession in terms of the prestigious nature of the legislation rather than any restrictions protecting the allocation of manpower.

> It [exclusive scope of practice] means something in terms of prestige, because there aren't very many groups in society that have exclusive scope. So nurses aren't going to like this very much if it goes. But in terms of the practical world, it probably won't change very much. (GP2, p. 21)

Perspectives on the Nursing Profession in Relation to Changes in Legislation

Legislation changes were not seen to be a panacea, but rather provided the means whereby legal restrictions between groups could be eliminated. Each of the interviewees in presenting their views focused on the reality that the future would be different from the past and that the design of that future would be centered on the establishment of new roles. None of the interviewees painted a 'doom and gloom' scenario.

One of the interviewees was particularly optimistic about what she saw as the changes in future nursing roles.

> I'm very encouraged by those nurses who are taking the advanced practice program at Athabasca University so that they can provide skills in primary care. I don't believe that we have yet seen the reform where we actually shift resources from the institutions to create community health centers and have opportunities for groups of professionals to work in a collaborative practice. I believe that will come, and I think that there will be a role for nurses, and I hope that they will seize that opportunity and take that challenge. (GP3, p. 24)

The same interviewee projected that the number of registered nurses would diminish, but those remaining would be better prepared.

> I think that there will always be room for nurses for the acute services in the highly critical areas like intensive care, in the operating rooms, recovery rooms. . . . I think nurses are still really well situated. [They have] been hit hard, there's no doubt about it, in the number of beds that have been closed and the number of personnel that we've lost in acute care. But I've sat across the table from nursing union leaders and professional association leaders in nursing who said, "We will have better-prepared and fewer registered nurses, and we are going in that direction." (GP3, p. 24)

In the view of this interviewee, much of the direct care would be provided by LPNs because they were seen to have the basic skills and were more cost-effective than registered nurses. At present, the baccalaureate-prepared nurse was seen to be performing a role similar to the diploma-prepared nurse.

> Even though we've encouraged our profession to move to a baccalaureate, they're still largely doing the same role as the diplomas, and yet most of what a diploma did can now be done by the LPN. And the truth of the matter is, the LPN is X number of dollars per hour lower [in cost]. (GP3, p. 25)

The 'shift upwards' she was describing would see nurses with advanced clinical preparation providing the supervision and coordination of much of the direct care activity, allowing lesser skilled and less costly workers to carry out basic care functions (GP3, p. 25). In responding to what she perceived would be the nursing reaction to a greater role for LPNs at the bedside she went on to say:

> You know what? It isn't a fair world, but I don't think we can worry about that if we can stay competitive and if we can now show that we could be more cost effective in doing some of that front-line work. If [they] specialize and if [they] move people through those clinical, master's programs, I'm sure nurses are going to be highly valued in the system. But to be honest, there's a lot of things that we once did at the bedside that others can do that are not going to make a big difference to the patient . . . like coordinating the care and ensuring that the throughput occurred and that the better transition was made as they went into home care. (GP3, p. 25)

In concluding her comments, she was particularly concerned that nurses would redirect their attention to the future rather than past.

> I think [they've] still got many opportunities, but we really have to get our forward eyes on and stop looking back. Now I'm preaching, but I think there's still and will be a role for registered nurses, and I think we'll have many things to let go of before we'll see them as opportunities. . . . But we can't have everything. . . . I just don't think that will serve the profession well. (GP3, p. 26)

Another interviewee was much more inclined to focus her comments on the impact of eliminating the exclusive scope of practice. It was her view that changing legislation was only one factor that would contribute to the reduction of barriers between professions.

> It isn't like you remove this—you go from one system to the other and things magically clear up. It has to be done in the whole context of the interplay between these professions. I don't see this being something that is entirely driven by just legislation. I think legislation is part of a whole

> changing process. I think within the various professions, nurses, for example, the movement towards independent practice, towards more expanded practice in nursing, is not going to be driven by changing legislation; the legislation has to be able to accommodate it (GP1, p. 25).

In reference to LPNs assuming more of the direct bedside care responsibilities, it was her view that this was not a new role for this group. She was of the understanding that the mix in staff complements had varied over time, and largely in response to cost factors.

> If anything, the perception is that it's the LPN that takes care of the bedside and the registered nurse is more likely to be in administration, overseeing the whole process. There are, I think, more economic issues here. . . . In hospitals the change in their mix between how many LPNs, how many nursing aides, and how many nurses. That has always been quite variable across hospitals and it varies over time. And hospitals have looked to that as a way of addressing their costing problems (GP1, p. 26).

In the view of this participant, eliminating the exclusive scope of practice, particularly as applied to medicine, would allow for nurses to practice in areas which formerly had not been possible because of restrictive legislation. However, in advancing into these areas, the critical factor was going to be fee schedules. In using the recent example associated with the use of midwives, she was uncertain how these and other similar services could be funded since there were only two options which she saw, that of a fee-for-service model or through institution-based budgets, neither of which had been particularly popular. Her conclusion was that even if legislation allowed nurses to engage in certain activities, implementation of such activities was directly dependent on funding allocation.

> I don't imagine there's much interest from a government perspective in getting into fee-for-service as we've known it in medicine. It may not be a problem that they're [physicians] prepared to address directly, but there's certainly reluctance to compound the problem. On the other hand, how do you deal with nurses going into direct service? One may have all the

> arguments in the world why you don't really need to see a physician as the front-line caregiver; nurses can handle this quite adequately. Who is going to pay for it? It all comes down to that in the end. (GP1, p. 27)

Another interviewee was much more philosophical in his discussion of the pending legislative changes. He was much less convinced that eliminating the exclusive scope of practice would result in the significant role changes in nursing which were being predicted in other government departments.

> I'm not very optimistic that there is going to be anything like the outcome that is often portrayed by the discussions that are going on now. I think there will be significant shifting, but I think it'll be far less dramatic for nurses than sometimes we are led to believe. (GP2, p. 18)

In discussing the shift in focus, he went on to describe the more recent roles being promoted by nursing leaders.

> If the exclusive scope of practice is removed, nurses will probably continue to do what they're doing, and they will probably continue to do higher-level work partly because they're better prepared to do that kind of work, and partly because more of them now believe that they're predestined to do that kind of work. I think they believe that they can and should, and their leaders are telling them that. . . . Also there is more opportunity for nurses to problem-solve and analyze and do that kind of practical and applied research in making the system better. (GP2, p. 16)

Part of what he considered as "higher level work" included roles formerly under the domain of medicine. With the elimination of exclusive scopes of practice, the opportunity was available for nursing to assume more advanced roles, though he too believed this change would be directly related to payment structures. In that regard, he was somewhat optimistic.

> I think that a lot of the things that doctors do are part of their mystique and don't need to be done by doctors. Doctors have been doing them because they decided that they are going to do them. I think that will happen [nurses assuming medical roles], and it's partly because of probably the

> assertiveness of nurses wanting to do that and partly because the health care system believes that it shouldn't be paying those kinds of fees for things that can be done elsewhere. (GP2, p. 17)

On the other hand, this interviewee wondered if the notion of highly skilled nursing practitioners providing similar services at less cost than physicians might be a "perceptual" issue. In referring to an interview with of a prominent nurse, he recalled that reference had been made to the fact that if nurses at a PhD level are skilled and competent, they should be reimbursed similarly to doctors. In his view, this circumstance would be unlikely to motivate any change in existing delivery systems (GP2, p. 18).

From the perspective of hospital-based service, it was his view that the role of nursing would largely remain the same, although with a greater prominence in the role of LPNs.

> I think in active treatment hospitals, nurses will continue to reign supreme, because they are there—they're the people that keep the place running. There are so many of them and they have their team stationed at all the doorways. . . . I think there will be some inroads made by LPNs and other complementary therapies. (GP2, p. 18)

Where he felt the role of nursing was particularly well positioned was in the provision of community service.

> I think in community care nurses have an excellent chance of coming out more or less on top of things, because they're well recognized; they have a broader level of training than others do. If you're travelling around Alberta in a car, you can't have five specialists in the car; you need somebody who is generically trained, and so I think nurses who are prepared to work in home care probably will still be highly desirable. (GP2, p. 19)

It was also his view that policy statements would play much less of a role than the internal development of the profession itself, given a changing environment. Like other interviewees, he felt that the future for nursing was more dependent on the assurance of initial and continued competence rather than depending on credential requirements and jurisdictional regulations to ensure a place in the workforce. In his words, "I think that nursing will evolve, based on the skills and competencies of people and their belief in themselves" (GP2, p. 16). However, in his view, nursing was experiencing the same dilemma as other predominantly female occupations. With women having a greater array of occupational choice, the pool of outstanding applicants was seen to be dwindling.

> I think nursing is facing a problem in recruiting. Not all young women think of teaching and nursing any more so that the numbers of highly skilled people coming into nursing is going to be different. . . . And so it may be that nursing can be as or more effective in the future operating at a different level, but they might have a different number of people operating in the group. (GP2, p. 17)

In the final analysis, this interviewee felt that the utilization of manpower had much less to do with legislation restricting who could perform which tasks than with overall costs. In his view this would become particularly apparent if less skilled workers continued to seek greater remuneration, particularly as advanced skills were acquired.

> It has more to do with getting the work done and the cost of the workers. I think that one of the worst things that could happen to the LPNs is if they got a raise that brought them close to nurses; then they would be far less desirable. So, in this system, it has less to do with skills and competencies than it has to do with cost of workers. (GP2, p. 20)

In reflecting on his experiences with health profession legislation and his recent involvement with the Alberta Health Workforce Rebalancing Committee, he remarked that "I came away thinking that the discussion of barriers was probably overstated" (GP2, p. 22). In recalling the original purpose of the exclusive practice clauses, he recalled that the legislation had been instituted because

> there were too many people running around with caps on that we couldn't read what the symbols meant. They could be doing all sorts of stuff that they weren't capable or qualified to do. And so the scopes of practice became clearer and are important. (GP2, p. 22)

While the exclusive scopes of practice may now be seen as the "extreme" of one end of the continuum, the other was to identify people, not by a professional title, but in accordance with what they could do. The idea that people would wear tags, for example, "I can deliver babies," seemed equally inappropriate to him. The overriding principle in his view was that government had to protect the public interest. His prediction of the eventual regulatory outcome of the Committee was that:

> We're going to end up probably coming a little bit more over toward flexibility, but the further we go, the bigger the risk is that the consumer protection obligation of government gets watered down. Then there will be lawsuits and complaints, and then we'll be pushed back the other way. . . . The discussion of barriers has a nice, political ring to it. It has logic to it, but the issue is, how do you implement it in a way that will operate without a huge administration checking everybody's credentials every few months? (GP2, p. 23)

However, he acknowledged that there was a perception that government should have less control over the governance of the professions and, in fact, less overall regulatory power. Therefore, it was his prediction that

> there will be a period of calm. . . . There will be less exclusiveness. There will be a greater expectation that occupational groups will be cooperative and work together more. Rather than creating boundaries between groups, they'll need to work together. There is no real benefit in being so separate. (GP2, p. 24)

However, as though not wishing to leave a message that the story was justly concluded and everyone would work together, his departing statement about the final outcome of legislation hinted otherwise. "It's not quite clear to me how that's all going to work yet" (GP2, p. 24).

A SUMMARY OF THE PERSPECTIVES OF THE GOVERNMENT RESPONDENTS

All of the government interviewees agreed that the stimulus for the nursing exclusive scope of practice had come from the nursing association as part of an overall objective to enhance the status of the nursing profession. However, government was a willing participant in the process, motivated by a number of concurrent and contributory factors. It was a time in which a number of nursing-related groups were pressing for legislation and thus an opportunity for government to establish an exclusive jurisdiction thereby inhibiting the proliferation of regulated practitioners. The decade preceding the introduction of exclusive nursing legislation had been a period of labour unrest within the registered nursing group, the result of which had garnered public support for nursing issues of low salaries and lack of recognition. Thus, approving exclusive legislation was seen by government as an opportunity to provide the professional recognition that the Association was seeking and to restore a 'tattered' image with the public and the Association. Employers were also supportive of exclusive legislation since it enabled them to implement their goal of all-RN staffing complements at a time when financial constraint was not a significant issue. And it was also a time in which the precedent of exclusive legislation had been established with several of the traditional health professions.

Mandatory registration was an area of much less concern to government stakeholders than it was for the Association. Because right-to title was included as part of any exclusive legislation, nurses were compelled to register with the Association if they wished to practice within the nursing area defined as exclusive. Because the nursing exclusive scope of practice was broad enough to encompass virtually any nursing practice area, government interviewees viewed mandatory registration for all practicing nurses to be an assumed part of this legislation.

From a government perspective, the interpretation of the nursing exclusive practice legislation was problematic. Although it was acknowledged that this legislation did not technically exclude other workers, there was a perception that it did. Gradually, what were considered professional practice monopolies became less revered as government began to seek alternate ways to respond to the increasing challenge of overlapping professional practice, yet cognizant of the responsibility to protect the public from the provision of potentially harmful services.

Following the enactment of the exclusive *Nursing Practice Act* in 1984, the 'world began to change' and financial issues became a much more prominent focus of health-related discussions. As employers faced declining budgets, attention turned to the largest of expenditures, manpower, and the related issue of utilization. Legislated scopes of practice, in contrast to the earlier approval they received, came to be seen by employers as obstructive to their desire to employ competent but less costly staff. Administrators retreated from an era of all RN-staffing by 'welcoming back' licensed practice nurses in the belief that they were competent to provide many of the registered nurse functions at less cost. This shift in hiring practices also coincided with a perception that educational programs were preparing nurses to coordinate services rather than provide direct care. Although the exclusive nursing legislation did not appear to constrain employers, the belief that current legislation was excessively restrictive remained.

In 1994 following the review of health legislation by the Alberta Health Workforce Rebalancing Committee, exclusive scopes of practice in all free-standing acts were eliminated from the proposed Health Professions Act as an attempt to remove the barriers to service provision. The registered nurses were opposed to this proposal, arguing that their exclusive legislation was not restrictive of other disciplines. They were also concerned with the advancing role of the LPNs, and expressed concerns about public safety and employer liability. Although it was not a 'cheery time' for registered nurses, also strained from significant cuts to health care budgets, in the view of the government interviewees, the proposed changes in legislation reflected the emerging realities that some registered nurse functions could be safely performed by other workers.

Government interviewees did not suggest an alternate model of health profession, preferring to discuss the implications of the proposed legislation. There were diverging views as to whether the outcome of the legislation would be as intended. All of the interviewees viewed this legislation as a means whereby legal barriers between groups could be minimized. Two of the interviewees felt that the elimination of the exclusive jurisdictions would enable registered nurses to assume roles not previously possible. On the other hand, it was predicted that the number of registered nurses would diminish and LPNs would assume more responsibility for direct care. This role change was seen to inevitable as all professional groups assumed additional practice skills. The third interviewee felt that, aside from the loss of a symbol of professional achievement, the elimination of the nursing exclusive scope of practice would have little impact on the profession. Although he also agreed that the nursing role would change, he felt that registered nurses would continue to dominate acute care and community services. All of the interviewees came to two conclusions; contemporary health profession legislation would reflect greater emphasis on the accountability of professional associations in ensuring a competent membership than on exclusivity of jurisdictions, and removing barriers to professional practice was significantly related to payment structures, a policy area involving its own challenges.

PERCEPTIONS OF THE RESPONDENTS
REPRESENTING THE PUBLIC

Three interviews were held in June 1997 with individuals who were chosen because of their background and interest areas. None of the individuals was currently engaged in a workplace in which they would be directly affected by any legislative changes. One of the individuals, who was semi-retired, had lengthy administrative experience in a large acute care hospital. Another interviewee was a non-health professional with extensive government and university experience. The third individual, a non-practicing physician, was currently engaged in an administrative role and was also engaged in health-related activities both provincially and nationally. Data categories were adapted to reflect the background of these participants. The responses of these individuals are reported according to the modified data categories. In order to maintain confidentiality, respondents will be referred to as public participants (PP).

Background to the Proposed Legislation Changes

As a preface to his comments on health profession legislation, one of the interviewees felt that any proposed changes should reflect basic principles which had been central to government policy direction and also had been integral to a number of government reviews which he had been involved with. As the interview progressed these principles were evident in his responses The first of these referred to the need for professionals to adapt to changing environments.

> We [professions] should not in any way feel that there should be some locked-in positions forever vis-à-vis the status of professions or the relationship between each other. It is a fluid situation and it has to reflect a new world. So this legislation itself represents change in a major way. (PP2, p. 1)

The second principle was that the purpose of the total health system was for the benefit of patients and the public.

> It is not a system set up for lawyers. It is not set up for bureaucrats or for researchers or professions. It is for those people who need service, and we must always remember that. And in some cases that had been forgotten, and systems had been set up where if you didn't fit into the system as a patient, that was too bad, because the system was all-encompassing, where I think the essence of this new piece of legislation tends to put the citizen very much at the front of the line. (PP2, p. 2)

The third principle was that of maximizing choices for individuals. "That I think is what this [legislation] does, and with that comes the concept of informed choice" (PP2, p. 2).

The Need to Regulate Health Professions

One of the interviewees was adamant that some form of professional regulation was necessary.

> Do we want individuals capable of doing everything and anything all of the time? I thought the reason why professions developed in the first place is because there is a recognizable body of knowledge and skills, and professionalism suggests that there is a unique body of knowledge and skills and that individuals commit to a profession for higher ideals, and includes the concept of self-regulation and self-governance and includes the concept of advancing the knowledge in that field. I don't think any of that should get torn down. (PP3, p. 3)

In the view of this interviewee, not only did professional regulation define the role of each profession, it also extended to include the management of professional groups. When asked if the traditional managerial hierarchy in service settings could offset the need for the current legislated exclusive scopes of practice, his response was not supportive of the trend towards 'generic' management roles. In his view, the non-specific professional managers did not "in any way" have the related professional skills to ensure safe practice within the supervised workforce (PP3, p. 19). In decrying the appointment of non-nursing managers, and using the circumstance of a system already too 'generic,' his comments were:

> "How well is that nurse performing in critical care? Will she [non-nurse manager] tell me?" What has happened is that management has become more generic and approach it from very many different backgrounds. . . . So, these people that manage and monitor now may or may not have content expertise in what they're managing and monitoring. And lots don't, in fact, and don't believe that there's anything wrong with that. (PP3, p. 19)

If the exclusive scopes of practice were to be eliminated, the question he posed was, "What do you replace it with?" (PP3, p. 9). If there were "no holds barred, . . . then how is it decided if a person is acting within a given skill set?" (p. 9). His further questioning reflected what he thought were the key issues from a practice perspective. "Let's forget all the administrators. Who's going to do what? And who is going to decide?" (p. 9). In describing a scenario from a practice arena, his response seemed to suggest that while exclusive scope of practice "may not be popular" it served a purpose.

> There's patients, they have needs and here are all of these providers. Do we inherently believe that every provider could in theory do the same thing? No. Do we want them doing the same thing? No. Do we want it linked with their education and their background and proven evidence of knowledge and skills in a particular area in order for them to operate? Yes. Is there anything that truly needs to be exclusive? I suppose at a gut and conceptual level, potentially the answer could be no, but you're going to make them exclusive because you believe you can probably manage it better, and cost-control it better. (PP3, p. 9)

However, although he believed that some practices should be exclusive, it wasn't as simple as a "menu-driven" concept: "There are certain things in every profession that are core to that profession, whether or not you've described them in terms of mutual exclusivity, absolute or not" (PP3, p. 2). He did not believe that the literal meaning of exclusivity should be adhered to. "No one believes that any more" (PP3, p. 4). In his view, some practices should be the exclusive domain of a given practitioner, although there were "always certain exemptions" to exclusivity (p. 10). The issue, as he described it, was how to resolve apparent inconsistencies.

> Surgical procedures [are] performed by physicians. Could you imagine the nurse practitioner ever taking a lump or a bump off the skin? Yes. Does that invalidate then that surgical procedures shall be done by physicians? I hope not, because I still believe that there are some exceptions. And I don't know how one approaches that, but I know that there's got to be regulation of the health professions, and I know it shouldn't be a free-for-all. (PP3, p. 10)

It was his view that the real question about overlapping practices should be, "How do you deal with the border zones?" He acknowledged that there were barriers between professions and para-professions and that there were a number of professional practices which could be assumed by less skilled workers. However, the concern for him was "absolutely not" the proposed elimination of the exclusive scopes of practice. As he said, "Do I care about that subject now? Not very much" (PP3, p. 5). What he cared about a great deal was whether those who were assuming additional roles were competent to do so. The focus of that concern, he believed, was properly directed at the accreditation of educational programs and the competency of graduates.

> [What]I do care about from a policy perspective, that people that are representing themselves to the public as professionals with capability in a certain area of practice have to have evidence that they have that capability, personally through their education and certification, and educationally, through the accreditation of programs through which they move. You have two levels of analysis; the program can do what it says it does, and the individual has gone through that program and has accomplished it. (PP3, p. 5)

Another interviewee was much less strident on whether professionals needed to be regulated. From her perspective the accepted practice was that professionals were licensed by an association, thus indicating to an employer that the individual was competent to practice. With the introduction of the nursing exclusive scope of practice she recalled there being some concern about the interpretation of the clause in relation to what the institution had historically seen as acceptable practice. However, beyond the initial concern she did not recall any particular barriers within the nursing department.

> I can't remember any real definite effect that it had on us in administration or having to change anything that we did, because we always required that our nurses were RNs, and we required that they update their registration every year. (PP1, p. 1)

In her view, when the *Nursing Practice Act* was proclaimed in 1984, the jurisdiction of the registered nurse was clear. In describing the concerns at the time, she recalled that

> there was concern that it might prevent them [CNAs] from doing some of the things that they had been doing. In some instances, there were levels of, say, dressings that a nurse would do, and there were some CNAs that could do some of those things. . . . Some of them were really excellent practitioners, and you'd let them do more because they seemed to be able to do more. There was concern that if they were going to define all the things that nurses could do with that act, that [it] might cause a problem with some of the things that we were having our staff do. . . . I don't think there was a lot of difficulty with that. . . . It didn't happen. (PP1, p. 2)

This interviewee understood that all professional staff were regulated to perform certain functions; however, it was also her belief that some staff could and should assume functions beyond regulatory boundaries. In her view, these overlapping functions, typically transferred from medicine to nursing, were adequately managed through a process of "transfer of function." From an administrative perspective, she viewed monitoring the competence of practitioners to be more important than a paper credential.

> Somebody should be checking, not [assume] that the person comes with a piece of paper to say, "Hey, I can do this." There should be somebody who's going to watch and check to make sure that that person is going to be able to perform the tasks well. (PP1, p. 7)

Barriers Created by the Present Form of Regulation

One of the interviewees felt that although the public had a right to expect quality and excellence in the standard of treatment, they also had a right to have efficiency, with "no waste" in the system (PP2, p. 7). His argument was that while there was concern with the potential use of less qualified workers within the health system, accompanied by the attendant quality issues, there was also evidence that there were tasks which could be assumed safely by less qualified workers.

> Those who argue that a person should never move up in terms of the complexity of the procedures they're doing—and these days graduate nurses or graduate physicians do far more than they did twenty-five years ago—I think are not correct in the sense that if a procedure can be done in a quality way at a quarter of the cost by someone with less training, . . . then that is the person who should do it. . . . It is manifestly, for example, a complete waste of a trained specialty physician to be working in the front line in a family clinic and dealing with people who need multiple inoculations. . . . That's not the best use of resources. (PP2, p. 8)

This same interviewee felt that the present professional legislation did not account for the technological advances and the accompanying role changes which were continuously occurring in each of the professions. Although the changes in traditional roles could mean a diminished number of professionals in some areas, the overriding objective was the interest of patients.

> There's a constant state of change, and they should recognize it within a profession. What physicians did fifty years ago, many of those things nurses are now trained to do and can do very, very well indeed. Both those professions are moving up, and therefore physicians should not feel threatened. . . . Similarly with LPNs doing things that RNs were doing. I

> think the argument of the protection of the public is fine, but I think that sometimes that is used to protect and to set up barriers around the profession, because it may mean there will be fewer numbers in a given profession, but whether there are or not, it's not something that affects the interest of patients, and that's who the system again is for. (H, p. 8)

Another interviewee did not see the present legislation as particularly restrictive, since there were processes which were customarily followed for managing such difficulties, at least in the organization she formerly was associated with. It was her belief that policies "set the direction and give you the framework that you work in" (PP1, p. 9).

> If the policy is very restricting [in relation to the performance of a task], then what we used to do is check through our medical people . . . to see if we could have somebody do a different procedure that was considered not [within nursing].

Factors Contributing to Change in Legislation

One of the factors influencing the proposed changes was the proliferation of professional legislation that had occurred over many years. According to one interviewee, the number and variation of professional acts had led to a very confused public. With the government continually being pressured to recognize additional groups, he speculated that the current number of twenty-eight health professions would increase if present trends continued and barriers between professional groups would continue to be promoted by the profession-specific nature of each piece of legislation.

> It's an historical development in the sense that the professions, as they each developed and sought to acquire greater status and greater exclusivity and monopoly; . . . they all grew up separately in separate little boxes and silos. The legal profession went in one direction, . . . and then we had barristers and solicitors, and health had another way in which they move. . . . We have a professional act for engineers and we have one for geologists. And then the geophysicists came in and said, "But we're separate." (PP2, p. 4)

It was his belief that pressure was being exerted from the public to at least combine some of the legislation, if not establish principles common to all professional groups.

> I think the public is driving this thing. [The public feels that] if they [professions] are to be given a monopoly and self-government and the privileges and the responsibility of disciplining the members, then let's have some fundamental guidelines, four or five that apply to all of them, and some way in which also we know that we are being protected. (PP2, p. 4)

The perennial conflicts between professional groups was seen to be another factor stimulating changes in legislation. In the view of this interviewee, government was responding to public pressure to 'sort this out' so that there would be regulatory similarities amongst all the professions. The structure within which this could occur was seen to be umbrella legislation.

> The public are not particularly interested in arguments of professions that they have had these rights in the past, and now they may be modified. The public says, "Surely they're mature enough, frankly, to sort them out. If they aren't, we think our government should." And I think the progress in that area, because professionals don't tend to talk to each other very much, has been glacial at best. Therefore the government I think has said, "We're going to set up an overall umbrella for all existing and all future unknown professions that may come along in 2050 and hope this serves the public interest." (PP2, p. 5)

Transparency in the process of self-governance, according to one interviewee, was another area in which the pubic did not feel well served.

> I think the public, rightly so, is saying, "If they have the privilege of these monopolies, then it must be very transparent so that we and others can judge the extent to which they are, for example, disciplining their members and not just protecting their members when they are professionally negligent." I think they'll be asked to try to come up with some basic approaches that could apply to each of them and criteria that have to be met before they can even come in the door, . . . the new ones. (PP2, p. 5)

Another area of concern with the existing legislation was the propensity for some professional groups, admittedly not health groups according to one interviewee, to monopolize the supply of members ultimately for economic gain.

> I think the concept of professions who are sometimes alleged to take actions to reduce or preclude an expansion of their numbers for the reason of restricting supply and therefore increasing their right to charge fees—that is going to be completely abolished or abandoned or precluded because that's not the purpose of the legislation. It's protection of the public. (PP2, p. 5)

One of the interviewees likened professional jurisdictions and exclusionary practices to a box in which each group wished to remain confined, unwilling to collaborate with other disciplines or even colleagues. This, according to this interviewee was becoming increasingly intolerable to the public who now were demanding collegial cooperation amongst professionals to resolve health problems. No longer was it acceptable for professions to require that patients somehow fit their needs around the interests of a particular professional.

> I think it's being driven by, again, the public interest of people who go in and, say, get an opinion with regard to some ailment . . . and the health provider says, "I don't know. I'm looking at the neurological side and it's not my responsibility in these [other] areas." And the patient will probably say, "It *is* your responsibility. You must cooperate for me, and with all the other disciplines that relate to what you're talking about. . . ." So I think it's been driven by the public who are saying, "Don't tell me that you can't help me because you're living in this box. I'm sure you're very good at this particular area but the world is built now in teams." The public is demanding teamwork, a reaching out on everybody's part, and are not patient at all with professionals who say, "You fit yourself within my area of special expertise because I am going to work within that box." (PP2, p. 7)

Two of the interviewees felt that patients were more informed on health care matters than in the past. One of the interviewees acknowledged that patients and citizens were able to acquire electronic information in understandable language very quickly. Thus, patients wished to have a choice in treatment regimes rather than being a bystander in health care decisions.

> I think all of this has brought about this sense of wanting to have greater choice, certainly relying on professions and saying as an individual, "I can't begin to have the knowledge that a nurse has about a certain degree of treatment and caring, but we're going to do this as a partnership." So I think this is part of the reason for the legislation, citizens wanting to be partners with their health providers, not subordinates to them. (PP2, p. 3)

The choices which the public wished to have in treatment regimes also included the alternative health system. As one interviewee described it, "There has to be an openness on behalf of all the traditional professions to look at alternative medicine" (PP2, p. 15). And, in the view of this interviewee, the government was in favour of alternatives to a perceived paternalistic approach to health care.

> Maybe some of these alternative things made from tree bark are of no proven value, but as long as the information is there . . . if people want to pay their own dollars to do that, they should have the choice of doing that. There shouldn't be some government or professional authority that says, "You are only allowed to seek these kinds of treatments." [Quadriplegics, for example,] are saying, "We want to be able to make even the wrong decisions, but we want the right of choice, because it's about the only thing we have left to give us a sense of self-worth." (PP2, pp. 15-16)

Another interviewee agreed that choices in treatment regimes were important to the public. However, from his perspective, what the public wanted was choice amongst treatment options, not providers.

> I don't know who is producing the rhetoric of demand that we want all this choice amongst the health professions. In fact, the more public I talk to, the more they say, "Now, look, don't bother me with that. I want to go there to get the information that I want." And they expect to get that from that health professional; they're not exactly out there shopping. . . . The public does want more choice, . . . choice in decision making; they want to be

> more involved: "Why am I having this surgery again?" They want that in spades. But I haven't heard a lot about choice for health professionals. I have never once in my life heard anybody launch a request or argument in favor of an LPN as opposed to a nurse. (PP3, p. 12)

In acknowledging the desire of the public to have a choice in treatment regimes, it was his view that the level of public knowledge still necessitated protection from charlatans.

> I'm afraid that I've got to view the public in a negative way as not being discriminating consumers and make the assumption that I've got to do certain things to protect them against the charlatans that are out there with their own motives and those individuals that are incompetent and may or may not recognize that they're not competent. (PP3, p. 18)

All of the interviewees agreed that changes in legislation was, in part, driven by professional groups wishing to expand their field of practice, yet restricted from doing so because of exclusive jurisdictions. As one interviewee stated, "There is a lot of advocacy for people to expand their venue and their scope of practice" (PP3, p. 1). One of the interviewees conceded that the phenomenon of 'pushing upwards' was widely recognized in the health hierarchy.

> The ones on the lower end of educational expenditure are . . . looking to expand. The ones on the high end are trying to prevent that. Doctors see the pressure from nurses pressing upwards. Nurses see the pressure [from] LPNs. . . . The push is always unidirectional from the bottom up. (PP3, p. 10)

Support by government for the utilization of less costly workers was also seen by the interviewees to be attached to economics. As one interviewee described it, "One imagines that part of the stimulus behind the changes in the health workforce legislation was that people would have then a basis to go to the lowest-cost alternatives" (PP3, p. 6). Support for the use of less costly workers was also inferred by another interviewee.

"We've got tasks that professionals were doing that they didn't need to do. You could have other workers do them" (PP1, p. 10).

Factors Affecting the Resolution of Barriers Between Professions

One of the interviewees felt that a major disincentive to more collegial relationships among health care professionals was related to the current fee-for-service payment structure. This, in turn, was related to "a lack of wanting to let go by physicians of procedures that others can do with lesser skills perfectly well" (PP2, p. 10). This interviewee believed that if given a choice of fee-for-service or salary with a pension, 50% to 60% of physicians would opt for the latter, commensurate with significant financial advantage. Should this alternative payment structure be made available, he predicted that "the whole mind set and some of these problems to access and to collegiality would change massively just overnight" (PP2, p. 11). In the view of this interviewee, the reasons why physicians were paid on a fee-for-service basis were

> fear of the unknown; and it's partly, I think, that fee-for-services is a convenient approach . . . and it's partly a fear of losing control. If you are in a salaried situation, one is a little less an independent entrepreneur and a little more an employee. (PP2, p. 11)

In discussing incentives to promote teamwork among professionals, another interviewee offered a similar, but less well defined recommendation. "We've got to change the payment system. . . . If I were a general practitioner that got paid for every delivery, then a midwife takes my income away" (PP3, p. 13). In his view, the reason nurse practitioners had not been utilized related to 'structural impediments.' "We need to set up different methods of reward and incentive, and then the collaborative team process will commence" (PP3, p. 13).

Another factor which was seen to promote the utilization of other workers rested within the delegative authority of the professions, which in the view of one interviewee, was an essential inclusion to any revised legislation.

> There has to be some basic rule there saying that any approved professional can delegate authority to another professional, subject to the governing college or professional group and their own good judgment. Bearing in mind the fact that they're liable if there is a problem. And it has to be left open like that and the responsibility left to the professional. Responsibilities given to nurses in rural northern Alberta are much higher and with no noticeable reduction in quality of services accessed than it is in the City of Edmonton, simply because of different traditions. (PP2, p. 10)

Umbrella legislation was seen to be a structure within which professions would be forced to talk to each other. According to one interviewee, collaboration between groups was also being promoted by a public who were coming to have certain expectations of professionals.

> [The public is saying that] the lines between these boxes are being blurred. They are saying, "If there's another specialist involved in this, I expect you to have talked to them. We don't live in silos any more in this world." So I think the citizenry are going to push that more and more, because everyone lives in a world where you have to make decisions in a range of multidisciplinary areas every day. (PP2, p. 12)

The structure of university faculties was also looked upon as a means of promoting better collaboration between related disciplines. However, it was the view of one interviewee that segregated educational processes had led to segregated practice environments. As he described it,

> Even though the public looks at their bodies as a whole and they're talking about the health of their system, we [the university] divided everything up into these funny boxes, traditionally, going back probably a hundred years. And, really, there should be one Faculty of Health on campus, and it should combine the elements of about five faculties. But it's very hard to make these changes, because we all have lived in comfortable areas and achieved

> research excellence and publication therein. We don't want to see that disappear and it causes trauma. (PP2, p. 13)

In his view the tendency for universities to continue supporting separate faculties of health-related disciplines was partly because of the

> very, very slow pace at which universities change their courses. And it's partly a feeling of exclusivity, that everyone likes to see themselves as senior to someone else, because the professions tend to like to feel that they are sort of senior to some professions. (PP2, p. 12)

It was also his view that as governments were less able to fund public universities that some combination of faculties would be inevitable and could have positive results: "I think that will drive some change too, and that will link up with what the public wants and link up with the professional council and its umbrella [structure] and will move the change forward" (PP2, p. 13).

Two of the interviewees were sceptical that the proposed legislation would stimulate the reduction of barriers between professions. In fact, one interviewee felt the opposite could occur: "The legislation won't promote collaborative practice. I suspect it's more likely to promote feuding about what should be in the border zones between the professions" (PP3, p. 11). He offered as the alternative that "the argument should come from within the professions, . . . arguing in the name of collaborative practice" (PP3, p. 11).

Another interviewee also concurred with the view that legislation changes would not precipitate significant alterations in the relationships between professional groups. Her comments suggested that institution-specific policies would likely continue to complement, if not supplant, any directives as to who could be engaged in certain practices, particularly as it applied to para-professional staff. In commenting on the impact of removing the exclusive scope of practice, she stated:

> I'm not sure it will reduce the barriers. Even though the act said there were certain things, there were still the policies that you had within your organization that stated what an RN could do and what an LPN could do. (PP1, p. 15)

This same interviewee cited circumstances in which the 'barriers' presumed to exist in nursing legislation had not been "followed up" (PP1, p. 17). In referring to staffing patterns in private long term care facilities she noted: "I hear about people that don't have an RN in their facility at night, and that's a real concern. You say, "How could that happen with the Nursing Act?" Well, it's been happening for years" (PP1, p. 17).

In summarizing her views of proposed legislation changes, she believed that the practice of nursing would eventually expand. In her view, "I think you're going to find that there may be nurses that hang up their shingle to do nursing practice" (PP1, p. 18). However, she felt this possibility was more likely to be generated from within the profession, although she acknowledged that the deletion of traditionally exclusive medical practices would facilitate changes for all other professions: "I think the individual disciplines are going to have to say what they're going to do, but without [medical] legislation to help them [physicians], it's going to be very difficult if a physician says that a nurse can't diagnose" (PP1, p. 19).

Another interviewee, in summarizing his overall views, felt that the proposed changes in legislation represented an overall desire by government to remove itself from direct involvement in the regulatory functions of all professions. Beyond establishing broad policies under which professions were to be governed, and maintaining ultimate responsibility for public safety, it was his view that in relation to the overall delivery of service, "government would be delighted to have someone else doing that" (PP2, p. 14).

> Governments realize that apart from areas of setting strategic policy and watching over monopolies, . . . they're not very efficient in solving problems or delivering the service. . . . They set the parameters and say, "You have to have these open, fair procedures for people. . . . You make

> sure you haven't got any bandits [because] it's your reputation, but you do it; we don't want to do it. . . . We'll [government] set up the framework and you run it. So, I think that is an increasing trend. (PP2, p. 14)

SUMMARY OF THE PERSPECTIVES OF THE RESPONDENTS REPRESENTING THE PUBLIC

In summarizing the perspectives of the participants representing the public interest, a common theme is provided if it was evident. However, because of the divergent backgrounds and experiences with professional regulation, the views of these participants tended to reflect an individual perspective.

In relation to professional regulation, respondents felt there was a need for some form of professional regulation, but there were a number of provisos in relation to the structure and function of an effective regulatory system. One of the participants was of the view that practice exclusivity, although of questionable 'popularity,' should be maintained, if for no other reason than it seemed to be provide a measure of control and cost-containment to the delivery of services. Another participant did not feel existing legislation was restrictive, and therefore defensible, contending that it was policies in the workplace which defined task allocation. However, this individual, as did the other two participants, readily acknowledged the existence of overlapping professional practices and therefore the need for practice exemptions within exclusive professional areas.

There were a number of barriers which participants felt were attributable to present forms of regulation. Despite regulatory restrictions, there were professional practices which could be safely assumed by less skilled workers. Some of the role changes, particularly those associated with technological advances, were projected to result in a diminished number of professionals in some areas. However, resistance to shift in traditional roles were seen, at times, to be more related to the protection of professional interests rather than the public interest.

One of the factors influencing current legislation changes was the proliferation of professional legislation that had occurred over many years and resulting in a 'confused' public. If, as speculated, the number of health professions increased, barriers between professional groups were likely to continue as each group pursued greater status and profession-specific legislation.

In relation to the amount and diversity of health profession legislation, there was a belief that pressure was being exerted by the public to establish commonality within legislation, greater transparency in disciplinary procedures, and for the professions or government to 'sort out' the perennial conflicts between professional groups. However, in the view of one participant, progress in relation to this latter circumstance had been 'glacial,' largely because, in his view, professions didn't talk to each other very much. In this regard, umbrella legislation was seen to provide the stimulus for interdisciplinary discussions. Related to professional isolationism, was pressure from the public for collegial cooperation to resolve health problems. Patients were seen to be more informed on health matters than in the past, and were pressing for choices in treatment regimes.

There were several factors which participants felt could lessen the barriers between professions. Current fee-for-service payment structures were considered to be a major disincentive to collegial relationships. If payment structures were changed to a salaried arrangement, one participant suggested the collegiality between professional groups would rapidly improve and another participant felt that the collaborative team process would truly begin. One of the participants was critical of the university's support for separate faculties of health-related disciplines. However, it was his view that as government became more financially constrained, some combination of faculties could be inevitable and with positive results relative to interprofessional relationships.

In projecting the outcome of the proposed legislation, two of the participants were sceptical that the legislation itself would bring about much reduction in the barriers between professions. One of the participants felt that the legislation may actually promote 'feuding' in relation to the 'borders' between professions. Another participant felt that institution-specific policies would likely complement, if not supplant, any directives as to who could be engaged in certain practices. In reflecting on the overall direction of the proposed policy change, one of the participants felt that the change in legislation represented an overall desire and an increasing trend on the part of government to remove itself from direct involvement in the regulatory functions of all professions.

CHAPTER 7

DATA ANALYSIS

Chapter 7 summaries the major findings of the data collection process described in Chapter 4, 5, and 6. This summary of findings is reported according to the major data categories established earlier. Where the findings reflect common perspectives or viewpoints, or where the findings are contrary to the common perspectives described in the literature review in Chapter 2 and 4, this will be indicated.

PERSPECTIVES ON THE HISTORY OF THE EXCLUSIVE SCOPE OF PRACTICE CLAUSE

Background

Licensing of professionals and some form of regulation governing claim to a field of expertise is not a recent phenomenon. In fact, as one interviewee recounted, the history of professional regulation dates at least as far back as the seventeenth century, when territorial disputes between the two traditional enterprises of medicine and mid-wives first erupted. Within the Canadian context, the discipline of nursing has a lengthy history, having achieved official status as the Alberta Association of Graduate Nurses in 1916, with a twenty-dollar registration fee levied on ninety-one members (AAGN, 1916). At the time, the provincial association was formed in spite of the prevailing view of government that adequate control of professional groups would not be served through self-regulation (Myskiw, 1992). Nevertheless, official legislation was to provide the nurses of Alberta with the foundation on which to develop their profession.

In the ensuing years, nursing, like other professions, embarked on a journey to full professional status. As the literature describes it and the history of the Alberta nursing association confirms (Myskiw, 1992), the pursuit of professionalism included: defining an area of practice, establishing standards of practice and education, expanding the educational base, claiming an area of expertise, training ancillary workers, declaring an exclusive scope of practice, and developing sub-specialties.

Prior to 1960, much of the legislative changes initiated by the nursing association was directed at the continuous upgrading of entry-level educational requirements. Following the inaugural Registered Nurses Act in 1916, each of the numerous amendments occurring over the next four decades reflected a tenuous agreement amongst nursing representatives as to how to balance entrance requirements in the wake of applicant shortages. During that time much of the nursing scope of practice reflected a role subordinate to physicians. Other than carrying out the simplest of patient care requirements, the nursing role was made up by the dutiful execution of doctors' orders.

Beginning in the 1960s, nursing was no longer satisfied with a role of subservience. With the introduction of college nursing programs, nursing education was being transposed from apprenticeship training programs to educational institutions, baccalaureate programs were expanding, and the Association had turned its attention to advancing itself as a professional group with emerging educational and practice standards. Subsidiary workers, or practical nursing aides, remained a part of the nursing workforce, having never relinquished their temporary status in fulfilling the chronic post-war shortage of nurses. Efforts to establish a professional bargaining organization were underway, culminating in the eventual establishment of the United Nurses of Alberta in 1977, distinct from the professional association.

By the early 1970s, the Registered Nurses Act no longer seemed adequate. This "little four-page act" (NP5, p. 1) had provided for protection-of-title. Registration with the association was voluntary, limiting the authority the Association could assume for a standard of practice. The need for mandatory registration became a central discussion topic in various forums over the next decade. However, it wasn't until the onset of labour negotiations in the early 1980s that the subject became more compelling. Furthermore, the professional pursuits of the Association seemed to lead logically to the aspiration for legislation similar to that belonging to other acknowledged professions. How this came about, then, is the subject of the next section.

Promotion of the Exclusive Scope of Practice Clause

All of the respondents in the nursing and government stakeholder groups were in agreement that the initiative for a nursing exclusive scope of practice clause had originated within the nursing association. Respondents representing the public interest were not sufficiently informed about the historical development of the legislation changes to comment beyond suggesting, as the literature would confirm, that it is virtually always the case that a profession initiates discussions concerning regulation, and always does so on the basis of public interest. Closely aligned with the exclusive practice clause was a perceived need by the nursing association for mandatory registration. The extent to which one was the primary motivator and the other a significant, but secondary motivator for legislation change varied in accordance with the source of discussion.

From the perspective of the nursing interviewees, all agreed that the primary motivation for the legislation changes initiated in the early 1980s was the achievement of mandatory registration. Although the arbitration hearings following strike action in 1981 had overturned a request by the United Nurses of Alberta for employers to be denied the right to require that a nurse be registered with the Association as a condition of employment, the Association was sensitized to how precarious the issue of registration could be. Up to that time, although registration was voluntary, it was the perception of the majority of membership, although incorrectly, that this was in fact a requirement to practice nursing. Since it was desirous that members register, the Association did little to dispel this actual misconception held by "ninety to ninety-five percent" (NP5, p. 9) of the membership. In the eyes of the Association, registration was seen as one of the symbols of a profession but, more importantly, it was the only means by which the public could be assured that standards of practice were maintained.

In 1981, and very shortly after the nurses' strike had been settled, the Association immediately embarked on formal discussions internally and with government representatives to have the existing Act changed to incorporate mandatory registration. Early into this discussion, it became apparent that required registration had to be 'attached' to a field of practice rather than to a credential or a title. On the advice of the legal consultant for the Association, and no doubt in keeping with the desire to confirm professional stature, the Legislation Committee at the time opted to pursue both a revised description of what nurses did, and a claim to what was exclusively done by nursing. Almost immediately the exclusive scope of practice clause became the foreground, perhaps because it was a symbolic reflection of what other recognized professions had achieved and therefore the ultimate trophy sought by an aspiring profession. On the other hand, the equally, if not more important mandatory registration issue, became background, always safeguarded in the knowledge that exclusive legislation would automatically ensure the requirement of mandatory registration.

The eventual wording of the clause had a generic ring to it. The two descriptors, 'caring for the physically and mentally ill,' and 'assessing the health of well persons,' were seen by the Association to capture, as best as possible, the essence of what nursing did, if not the essence of what many other professions did. However, the apparent simplicity of the wording did not resolve the struggle to define what was distinctly nursing despite several years of discussion. The College of Physicians and Surgeons immediately recognized the intent of the clause as identical to their exclusive jurisdiction, withholding their sanction until the phrase, 'the application of nursing knowledge' was included to quell their concerns. The addition of reference to medication administration as an exclusive nursing function was also added at the recommendation of a government representative, in an attempt to reflect a distinct nursing function not apparent in the first two descriptors. According to the nursing interviewees, there was some trepidation about this addition, a reservation which was confirmed by later events.

With the enactment of the revised nursing legislation in 1984, the Association and its membership regarded the accomplishment as a milestone, if not the arrival from a lengthy, sometimes tumultuous, journey. Each of the interviewees expressed the importance the legislation had for the Association, and the rejoicing that the profession had 'moved into the twentieth century' commensurate with other 'senior' professions. Also of note, although not acknowledged by the nursing interviewees, was the name change from the former *Registered Nurses Act* to the *Nursing Profession Act*.

Each of the three government respondents was able to provide an enriched description of the policy environment at the time, having been privy to prevailing circumstances. All of the interviewees agreed that the AARN had initiated contact with government to have their legislation revised to include an exclusive scope of practice clause. In fact, discussions on the subject had taken place with government over an extended period of time. However, it was the consensus of the interviewees that while mandatory registration had been foremost on the nursing agenda, it was the exclusive practice clause which received the attention of government. The rationale at the time was that an exclusive practice clause would subsume a requirement for mandatory registration, not the reverse. While this thinking seems to have changed in relation to current, proposed changes, the Nursing Profession Act passed in 1984 contained the exclusive scope of practice clause. However, there was no direct reference to mandatory registration although this was assumed to be part of the exclusive legislation.

Each of the government interviewees defended the inclusion of the nursing exclusive practice clause as consistent with the era in which it had originated. At the time, while the nursing association had been the initiator, government had been a 'willing cooperator,' wishing to be seen as proactive in supporting the Association in its pursuit to enhance the professional status of nursing as a discipline. Government support for the nursing agenda was further buttressed by the presence and guidance of an MLA from Calgary and an influential member of the AARN. However, there were a number of factors operational in Alberta which collectively contributed to the enactment of what seemed appropriate legislation at the time.

The most significant of these factors seemed to be the labour unrest within the nursing group. Nurses were anxious to be seen as a discipline separate from medicine with commensurate recognition and financial remuneration. In fact, at the time, nurses enjoyed a good deal of public support, not unnoticed by a sympathetic and resource-rich government as yet unencumbered by any apparent need for financial constraint. Thus deferring to the request for exclusive practice legislation would, in part, provide the nursing group with the sought after recognition, bringing the group in line with other traditionally recognized professions, and place government in a favourable light with the public.

It was also a time in Alberta, when, from a government perspective, there were a growing number of disciplines who were also seeking their own legislation. Uncertain as to how to impose some form of regulatory order on the many requests for professional recognition, government viewed the nursing exclusive scope of practice as a timely solution. As a means to curtail the attempted expansion of other professions, the questionable claims to jurisdictions could be effectively dispelled as infringing on what was an area exclusive to nursing practice.

Another, and not insignificant, voice of support for a nursing exclusive scope of practice was being heard from employers. All-RN staffing patterns were being proposed throughout North America as the most efficient and cost-effective form of manpower allocation. Not wishing to be out of step with these latest trends, Alberta employers conferred their support on the pending exclusive legislation as a means to substantiate their claim for preferred staffing patterns and their disinclination to hire licensed practical nurses.

The timing, therefore, for legislation changes was opportune. Rarely would all stakeholders representing the profession, government and employers be so unified in their affirmation of the proposed changes. With the consensus that 'the intent was good' and that it 'made good sense,' the exclusive practice clause was incorporated in the new Nursing Profession Act, January 1, 1984.

Interpretation of the Exclusive Scope of Practice

The Alberta Association of Registered Nurses (AARN) has had a long history of attempts by its membership to define precisely what nurses do. As several of the nursing interviewees suggested, the practice of nursing is seen to be a broad jurisdiction lending itself to broad and generic definition. The exercise of defining nursing as an exclusive jurisdiction was no more successful than it had formerly been. The first two descriptors in the clause, that of caring for the physically and mentally ill, and caring for and assessing the health of well persons, were obvious to nursing and all other health disciplines as descriptive of the practice of every health profession and could also be extrapolated to refer to anyone caring for an ill person inside or outside of the health care system. In an attempt to try to add a descriptor to the legislation which was truly unique to nursing, a third clause which made reference to the administration of medication was included at the recommendation of a government bureaucrat. In the latter case, the clause was seen to add a degree of public protection, preventing both licensed practical nurses and aides from carrying out any activity which could be construed as medication administration, particularly at a time of registered nurse shortage. It is noteworthy that an individual who was directly involved in the legislative process at the time contested the view that medication administration was a clause recommended by a government bureaucrat. In a personal communiqué, she noted that the clause was added to the legislation at the request of the Nursing Legislation Committee in order to mark a distinction for nursing.

Although the nursing exclusive scope of practice had the potential to precipitate immediate challenges by other health disciplines, with the exception of medicine, this has never occurred, at least publicly. The challenge from medicine that the nursing legislation transgressed the boundaries of physicians could hardly be denied. Thus the suggestion by the College of Physicians and Surgeons that the phrase "the application of nursing knowledge for compensation" be affixed to the exclusive clause, was readily endorsed by the nursing association as a solution to what had been an unresolved attempt to establish clarity of jurisdiction. The addition of this phrase calmed physicians and likewise immediately signalled to other health professions that, since they were not applying nursing knowledge, incursion on their jurisdiction was not threatened.

Non-nursing jurisdictions were further safeguarded in relation to another key aspect in legislation. Each of the free-standing professions and those encompassed under umbrella legislation had in their Act a clause which allowed for an exemption from any restriction or interference from other professional groups in relation to overlapping practices. Thus, the exclusive practice clause in nursing, while depicting a potentially broad jurisdiction, was never used to challenge non-nursing practitioners. Each of the nursing interviewees made reference to this point, indicating that the Association was well aware of the legal limitations of the clause. Thus many of the interviewees emphasized that the lengthy commitment by the Association to embed the exclusive scope of practice in legislation was ultimately to embellish the professional status of the discipline. The intent had never been to restrict the practice of other professional groups. It was also acknowledged that these circumstances were unique to nursing. In the case of all other professions with exclusive scope of practice, because the clause was typically very specific to the profession, it was implemented with the intention of restricting a field of practice.

Although the first two clauses in the exclusive of practice did not seem to cause significant concern for other professions, the third clause which referred to the administration of medication prompted closer scrutiny. The sources of concern predictably came from the licensed practical nurses, or perhaps more correctly from the employers of these workers. It had long been the practice for this group of workers who predominated in the long-term care environments to be involved in the administration of oral medications to patients. However, while this practice was widely acknowledged and opposed by registered nurses, the Association never used their legislation to stop this practice.

The circumstance had sparked great debates amongst registered nurses as to what aspect of medication administration should remain the domain of nurses. However, the Association was clearly of the opinion that many individuals were involved in the giving of medicines to others and that to challenge such activity would prove to be useless. Thus, it was unanticipated, but nevertheless not surprising, that shortly after the exclusion was established in legislation, a number of groups, sometimes gratefully, indicated that they would no longer be able to give medications, for example, to sick children in various non-hospital settings. As the responses from the public became more nonsensical, and the need for multiple exemptions seemed the only solution, the clause was deleted from the legislation three years after its inception.

Many registered nurses predicted that the deletion of the medication exclusion clause would 'open the door' for licensed practical nurses to administer medications, and would be quickly followed by a series of other tasks traditionally considered the domain of nursing. In reality, LPNs were already engaged in aspects of medication administration, and the fact that they had, in 1983, been included under the Health Disciplines Act, further exempted them from any restriction resulting from the nursing exclusive scope of practice.

However, under their new legislation, an LPN would continue to work under the supervision of a registered nurse, a registered psychiatric nurse, or a physician. Thus, although the LPN was entitled to carry out a defined list of health care services in accordance with their Act, it was primarily the registered nurse who controlled their practice through the delegation and supervision process.

Shortly after the exclusive nursing legislation was enacted, policy-makers began to view the legislation as problematic. The initial signal that the legislation "may have gone too far" (GP2, p. 7) was prompted by the external response to medication administration as an exclusive practice. Although they acknowledged that the legislation was in legal terms not restrictive of other professional groups, there was a perception that the legislation implied a restriction. In the view of the government respondents, although the nursing profession had not acted on the clause to exclude others, the wording itself continued to suggest that "the jurisdiction was exclusive" as one interviewee described it (GP1, p. 25).

The nursing exclusive scope of practice was likened to the similarly broadly stated exclusive clause for medicine. Referring to the exclusive practice as being a euphemism for monopolies, it was the view of the government respondents that the original intent was that groups such as medicine and nursing were allowed to control their own practice area in return for governance that was in the public interest. Although speaking generically, it was the view of the respondents that governance "had not been entirely without self-interest" (GP1, p. 6).

Nevertheless, for a time the public had been accepting of a paternalistic approach to service delivery. However, as the public became a more informed consumer of health services, this approach became less tolerable. Adherence to exclusive practices were becoming less acceptable to the public, who were demanding that professions ought to be accountable beyond their domain. Further, there was a diversity of professionals emerging, bringing with them the confusion of overlapping functions despite a more educated consumer. Historic interpretations of professional exclusivity and guarded exposure of professional governance issues were no longer in step with changing times.

Expressed Positions of Stakeholders

From the perspective of the nursing interviewees, the exclusive scope of practice had been more symbolic than instrumental. Several used the term 'pride' to describe the response of the membership to the acquisition of the legislative change when it was introduced in 1984. Others spoke of the clause as symbolic of the professionalism which the Association had finally achieved and, for that reason, an 'icon held dear' as a mark of accomplishment.

However, nursing interviewees did not link exclusive scope with any legal right to restrict the practice of other practitioners. Although they acknowledged the legal potential of the clause, they were conclusive in their comments that this had never been the intent and that the legislation had little probability of being upheld if challenged because of its generic description. This former claim was substantiated in that only one injunction had been served in thirteen years and was reportedly upheld, although circumstances were not clear. The summation of nursing comments was that the legislation was not restrictive because the generic terminology overlapped with many other disciplines.

For most staff nurses, the exclusive scope of practice, other than conveying a mark of professionalism, bore little effect on their day to day practice. Several of the interviewees, including one of the public representatives, referred to an 'understanding' between registered nurses and LPNs in relation to the workplace. It was their contention that nurses in the field were relatively clear on their role, and furthermore were clear and satisfied with the delegation of certain activities, and the accountability, responsibility and reporting structures relative to ancillary workers. Several cited instances from their hospital experiences wherein the delegation of tasks from registered nurses to licensed practical nurses had been made more out of respect for competency than credential. And, beyond an initial concern that the introduction of the nursing exclusive scope of practice clause might raise questions about commonly accepted and endorsed nursing practices, the division of labour remained relatively unchanged and relationships remained positive.

However, two trends emerged which affected the allocation of responsibilities within the nursing ranks, altering what had been a relatively amiable relationship between the two groups. First, there was evidence throughout North America that nursing administrators were preferring to hire only registered nurses, citing the cost effectiveness of having fewer but more broadly skilled staff. Nursing departments in Alberta hospitals, particularly large teaching hospitals, endorsed this staffing philosophy for a time in the late 1970s and early 1980s.

The response of lesser skilled staff to their potential demise probably contributed significantly to the second trend, at least in Alberta. The Professional Council of Licensed Practical Nurses (PCLPN) embarked on a course of action to have the role of the LPN recognized and respected. Commended for their vision by several of the interviewees, the PCLPN successfully lobbied for their own legislation and established a series of advanced educational programs to enhance their scope of practice, one of which was the administration of oral medications. According to several of the nursing interviewees, it was this specific addition to the LPN role and, secondarily, other program enhancements which seemed to stimulate the division between the two groups. However, as these interviewees wished to make clear, it was the promotion of professionalism at the association levels of both the registered nurses and LPNs which had led to the divisiveness at the level of service delivery.

The utility of the nursing exclusive practice clause was challenged by the interviewee representing the PCLPN. Although she emphasized that the clause had "no effect" on the LPNs since they were governed under their own legislation, she was critical of the AARN for not having exercised their legislation to challenge the more significant problem of unregulated workers who had received little or no training and were not governed under any legislation. In her view the attention to scopes of practice for the regulated groups had ignored the more pressing problem of unregulated workers performing tasks which were potentially unsafe. She did not make direct reference to the point that some of these tasks had traditionally been within the jurisdiction of the LPN, and therefore a challenge by the AARN regarding infringement in an exclusive area would have the double advantage of protecting the public and strengthening the LPN role. Nevertheless, her conclusion was that the exclusive legislation had been of nebulous utility and since it had never been used as legally intended she saw no reason why it should continue to be retained.

Any notion that exclusive scopes of practice were unnecessary was vigorously denied by one of the public representatives. He was in fact supportive of the views of the nursing interviewees that exclusive scopes of practice, on one level, represented the essence of professionalism and the substantiation of a recognizable body of knowledge unique to a given profession. It was unfathomable to him that any consideration should be given to eliminating this professional characteristic, a circumstance which he speculated could lead to a "free-for-all" (PP3, p. 10) in determining who could perform certain functions. Conversely he was open to the idea that exclusivity may not preclude exemptions. He readily acknowledged overlapping roles, particularly between medicine and nursing, and therefore supported the notion that while there were core elements (which were presumed to be exclusive elements) to every profession, there was a place for other practitioners with proven competencies to share jurisdictions.

All of the government respondents agreed that exclusive scopes of practice embellished the professional stature of a discipline. What they were less enamoured with was the increasing number of complaints from the public claiming to be dissatisfied with unnecessary restrictions on health services. In their view there was evidence to suggest that exclusive clauses had not prevented unqualified individuals from delivering services. Furthermore, it was their belief that protected title offered similar protection to exclusive scope without necessitating the need for exemptions because of increasingly overlapping practices. Since it was considered the responsibility of government to protect the public from those providing blatantly dangerous services, but to do so with as few regulations as possible, it was their view that exclusive scopes of practice exceeded reasonable boundaries to protect the public. In reflecting the view of the group, one individual asked, "If services are provided by safe, competent, ethical practitioners with protected title, what is gained by having exclusive scope?" (GP3, p. 3).

PERSPECTIVES ON THE ELIMINATION OF THE EXCLUSIVE SCOPE OF PRACTICE CLAUSE

Principal Stakeholders Promoting a Need for Change

All of the nursing respondents indicated that government had been the primary initiator of the proposed changes to health profession legislation. When queried about their role in the change process, government respondents concurred with the view of the nursing respondents. However, it was their view that the government-initiated public forums and the subsequent evolution of the Health Workforce Rebalancing Committee had been prompted by pressures from both employers and the public.

What inevitably became a circular discussion point was the influence of economics. Nursing respondents believed that government, as initiator, was acting largely from a position of wishing to reduce health care costs. Government respondents acknowledged an economic factor, but preferred to identify the principal stimulus as employer and public pressure. What was very clear was that none of the professions had requested to have their own exclusive practice clauses deleted. However, in at least the case of the nursing profession, the perceived restrictions on enhanced nursing practice generated by the exclusive scope of practice for physicians had been the subject of discussions with government officials.

Factors Contributing to the Elimination of the Nursing Exclusive Practice Clause

Of all of the questions on the interview schedule, the respondents seemed most vocal in their description of what factors had contributed to the proposed legislative changes. There was consensus on many of the factors, although some interviewees brought forth circumstances not reiterated by others. Most of the comments centered on events which had occurred in the 1990s. Only one respondent, a government respondent, made reference to policy documents or reports which had been generated over the preceding eighteen years. An analysis of these documents revealed that some of the factors regarded as influential in the proposed changes had been rooted in much earlier government policy statements.

Early Influences of Other Provinces on Proposed Policy Changes in Alberta

Three of the respondents made reference to the influence of policy development in other Canadian provinces on Alberta policy. One of these respondents was convinced that Alberta legislation was very much patterned after legislation in Ontario. Two of the government respondents made casual reference to legislation in other jurisdictions, though not wishing to give undo emphasis to the notion of duplicating in Alberta what had occurred elsewhere. However, despite this response, the similarity of expressed concerns and policy statements between provinces could only lead to the conclusion that Alberta bureaucrats and politicians were clearly aware of and influenced by external events. In explaining this circumstance, Boase (1994) claimed that, in relation to health discipline policy,

> the provinces assiduously protect their right to tailor their own plans to their own constituencies. Public servants in Alberta were very aware of policy decisions being made and considered in other Canadian jurisdictions and believed that this awareness was helpful when they were drafting legislation. (p. 59)

Two of the provinces which seemed particularly influential on Alberta legislation were Quebec and Ontario, both of which commissioned studies concerning the regulation of health professions in the 1960s. Both the Castonguay Commission in Quebec and the Committee on the Healing Arts (COHA) in Ontario had, as part of their mandate, the review of legislation governing the traditional professional groups and the burgeoning number of health care occupations seeking formal recognition. An overview of these two committees has been presented in Chapter 2. It was noted that the recommendations from these reports reappeared, almost verbatim, in subsequent reviews and position papers in Alberta. Most noteworthy of the many recurring themes were the following: concern about the monopolistic character of existing licensing processes, the need for lay representation on governing bodies, effective disciplining measures, evidence of continuing education requirements, utilization of paramedical and allied health personnel, greater public input into regulatory policy and quality standards for services, and the need for increased freedom for patients in receiving treatment from a professional of their choice. Of equal significance was the eventual absence of many of the recommendations in subsequent legislation in both Quebec and Ontario (Boase, 1994, p. 66). Nevertheless, the reports were considered landmark studies in identifying changing societal perspectives on professionalism and the theme of these reports continued to manifest itself, albeit with lack of success, in provincial policy positions and reports some thirty years later. In an interview with I. R. Dowie, fifteen years after the release of the final report of the

Committee on the Healing Arts in Ontario which he had chaired, Boase (1994) recalled his reference to the dismal record of Canadian governments in the implementation of the recommendations of appointed commissions. Her conclusion was that the apparent propensity for activity without action was a reflection of the "seemingly intractable problems inherent in a complex system where governments grant wide self-regulating powers to ambitious professionals: (Boase, 1994, p. 66).

Early Influences From Policy Statements in Alberta

Similar to other provinces, Alberta had a legacy of policy statements relating to professional legislation dating back to 1972. Unlike other jurisdictions, the Alberta reports reflected statements of purpose or guiding principles governing professional legislation rather than a detailed examination of occupations. One of the government respondents made general reference to a policy position established by the Alberta government "sometime in the early 1980s" (GP3, p. 4). The other two government respondents made no mention of any earlier government policy statements which might have influenced the present proposed changes.

In fact, there were at least four reports on professional legislation in Alberta which provided evidence, albeit general, of the government position and arguably provided background information to the Health Workforce Rebalancing Committee. A detailed description of these reports was outlined in Chapter 4. Of significance in the analysis of these documents is the consistency of themes which have persisted over the past 25 years, themes which have also dominated similar discussions in other provincial jurisdictions. Legislative goals such as protection of the public interest, cost effectiveness in the provision of professional services, freedom of choice with respect to professional services, protection of the rights and freedoms of individuals, enhanced awareness of available services and complaint procedures, continuing education and high standards of practice, balance between delegation and retention of government authority over the practice of professions and systems of licensing which do not unduly restrict access to the professions, have all appeared with recurring frequency in each document (Government of Alberta, 1972; 1976; 1978; 1990).

However, as one of the government respondents noted, despite "clear goals" (GP3, p. 5) little seemed to change, voluntarily, in regard to professional self-governance. From a government perspective, concerns persisted about the proliferation of occupational groups pressing for legislation, growing public confusion and suspicion with professional governance processes, and the seemingly insatiable pursuit by occupational groups for professional status by upgrading educational requirements, expanding scopes of practice, and acquiring ancillary workers to perform routine tasks.

Parallel to the issuance of government policy papers were two other circumstances which further sharpened the issues surrounding professional self-governance. Nursing had been 'rewarded' with a broadly defined but exclusive scope of practice in 1984. Almost immediately after the *Nursing Profession Act* was proclaimed, one of the government respondents recalled that statements from bureaucrats and politicians suggested "the legislation had gone too far" (GP2, p. 7). With a barrage of complaints from personnel in nursing homes, senior citizens' lodges, homemakers, community workers, psychiatric nurses and teachers, policy makers suspected that the legislation had not taken into consideration a full exploration of the significance of the restricted practice. Lawyers were predicting legal entanglements generated from jurisdictional disputes and Ontario indicated their dismay with legislative precedent in Alberta which would ultimately lead to pressure from nursing groups in other provinces seeking to obtain similar recognition. Although in both cases the predictions did not come to fruition, an atmosphere of sensitivity persisted in recognition of the awareness that the exclusive practice clauses for all disciplines were not "neat packages" (GP2, p. 8).

A second circumstance which sensitized policy makers to the limitations of exclusive nursing legislation was the increasingly popular role of the LPN. This group of workers was beginning to emerge as an attractive alternative to employers sceptical of the cost-effectiveness of an all-RN staffing trend evident in the early to mid-1980s. Although LPNs were regulated under umbrella legislation and therefore were exempted from registered nurse legislation, the perception amongst employers was that the new exclusive nursing legislation unnecessarily restricted the LPN from performing tasks previously thought to be acceptable and safe.

What had become clear over the years of policy papers and the continuance of disciplines being accorded exclusive practice jurisdictions, in the view of government respondents, was a disquieting sense of discomfort amongst policy makers. Significant inroads into changes in professional governance had not occurred and exclusive practice legislation was not as "clean and exclusive" as it had first appeared (GP2, p. 10). Thus, as respondents described the factors they perceived to be the stimulus for the most recent legislative changes, many of the same themes continued to be prevalent although with one significant variation. As one respondent described it, "The world began to change" (GP2, p. 10) and the issue of health care costs became much more central.

Factors Affecting Changes in Legislation in the 1990s

Virtually every respondent attributed the proposed legislative changes to the economics of the health care system. In fact, had there not been a need for government to reduce spending on health care in the 1990s, it could be speculated that although the discussion of professional legislation would have continued, little would have changed in the overall professional landscape. However, to suggest, as some nursing respondents did, that economics was the only driving force, provides an overly simplistic interpretation of what were a collection of contributing factors. Furthermore, this economic view did not reflect the changing views of professionalism acknowledged by several of the respondents, and evident in the literature review. Nevertheless, the need to reduce health care spending became the platform on which concerns, long associated with professional legislation, once again emerged.

One of the predominating economic rationales for legislation changes was the perception, particularly amongst employers and government, that removal of barriers to redefining a more cost efficient health system was necessary. Although all respondents referred to 'barriers,' the term came to have a variety of meanings depending on the perspective of the respondent. From the perspective of the interviewees, the phrase was seen to have several interpretations which included barriers to the employment of emerging or alternative health professions, inability of the public to select health services and providers of their choice, inconsistent and cumbersome legislation which confused the public if not the professions, and unproductive competition over turf rather than collaboration between different types of health professionals. Each of these factors was described to varying degrees by all respondents and are outlined below. Also described are additional factors seen to be contributory to the elimination of the nursing exclusive scope but which were mentioned by selected respondents. In both cases, what emerged from the discussion was the apparent interrelatedness of factors, rather than a discrete description of causation.

Allocation of manpower. The most frequently mentioned and significant factor contributing to the proposed changes in professional legislation was that of disenchanted employers who were experiencing unprecedented reductions in their operating budgets. In what was described as a shift from a need-driven to a resource-driven budget, employers for the first time, were given a fixed and significantly reduced budget with the responsibility to continue providing quality care at a similar service level. As the most cost-intensive budgetary component, employers had no alternative but to re-examine the utilization of human resources. Managers questioned the traditional allocation of manpower, and the extent to which practitioners were being used to their maximum potential. There was a hasty retreat from the trend to all-RN staffing, and LPNs were being welcomed back as a safe and low-cost practitioner. Historic discussions of physicians being most appropriately utilized in secondary and tertiary-level services with nurses assuming aspects of the primary health services were revitalized. In short, the concern seemed to shift from an emphasis on credentials and traditional scopes of practice to the skills and tasks which could be safely performed by the least costly worker.

When faced with the magnitude of the difficulty of providing similar service at reduced cost, employers began to target legislated scopes of practice as a barrier to more flexible staffing allocations. Furthermore, existing legislation was not seen to account for the technological advances and the accompanying role changes which had been central to the history of professionalism. In the case of all of the professions and ancillary groups, present roles were significantly different from what they had been decades earlier. Employers regarded advances in the technical expertise of the professional groups as an expected phenomenon, and one which had to be reflected in the allocation of human resources. To a large extent, existing legislation hindered the inevitable 'moving up' progression, with professional groups particularly resistive to advances from those traditionally seen to be subordinate.

Not only were administrators wishing to apply different staffing patterns in hospitals, but the emphasis on community care was prompting the need for broadly skilled workers. It was in the latter case that the notion of generic multi-skilled workers, imported as an efficient means of staffing in some American hospitals, had enjoyed a brief period of popularity. Although the idea was rejected by all professions as a viable solution to manpower needs in Alberta, employers continued to press for the authority to hire broadly skilled workers unencumbered by the perceived restrictions of exclusive scopes of practice.

The wishes of employers were further fuelled by a growing awareness that the original intent of at least the nursing exclusive scope of practice had not been realized. Although this clause was originally intended to protect the public, there were instances where the public was apparently not protected from unsafe care. In this regard, employers were asking why they should not be able to have LPNs give certain medications, when the nursing exclusive scope had not prevented unsafe practice, and there was no evidence that utilizing alternative workers was unsafe. The message from employers, according to both nursing and government respondents, was not to imply that there was rampant evidence of unsafe practice. What was being pressed for were defensible answers to the seemingly indefensible question of why less skilled but still safe practitioners could not be utilized. The fact that exclusive jurisdictions precluded the use of alternative care providers no longer seemed acceptable to employers.

The utilization of manpower was further complicated by a perception held by government respondents of the role of registered nurses. Although this perception was emphatically denied by nursing respondents, it nevertheless was an honest misunderstanding or a convenient explanation circulating in three government departments. The contentious perception was that registered nurses were actually striving to move away from direct bedside care, preferring instead to be the coordinators rather than the deliverers of care. Government respondents claimed this perception had been gleaned from the knowledge that the AARN was pushing for master's and PhD-level education programs which were intended to prepare nurses to be managers, counsellors and problem-solvers, not technicians, and certainly not "handmaidens to physicians" (GP2, p. 14). It was with this perception as background that government was being pressured by the PCLPN to be recognized as a suitable alternative for the delivery of direct patient care, a request which employers also seemed to be endorsing. The means to this end, therefore, seemed to be the removal of unnecessarily restrictive legislation.

Public choice of service and providers. Closely aligned with the perceived barriers to manpower planning was the increasing desire of the public to have access to a broader spectrum of health service and providers. It was acknowledged by most respondents that patients were more sophisticated and informed consumers of health care services than had been the case in the past. With access to computer technology, patients and the public were able to access vast amounts of user-friendly information. No longer content to have patriarchal physicians as the primary gatekeepers of the health system, the public was demanding knowledge of their health status and appropriate treatment choices. Recent circumstances of pregnant women wishing to access the insured services of midwives was cited by several respondents as an example of the shift to a consumer-driven focus. However, midwives were only one such example. The public was also wishing direct access to dental hygienists and physical therapists (which had been recently granted), as well as denturists and opticians for treatments generally regarded to be in the realm of other more senior disciplines.

The need to look at multiple entry points to the health care system also prompted questions about the existing referral system. With the control of jurisdictions through exclusive scopes of practice, government was questioning the number of duplicate tests and treatments incurred by patients who were required to obtain a referral, usually from a physician, before proceeding on to a preferred treatment choice. The change to direct access to physiotherapy was praised. However, there were other circumstances where there remained restrictions more reflective of professional rather than public interest. Most notable of these were the fields of dentistry with its collection of sub-groups, all under direct control of dentists.

The growing popularity of the alternative health system was another arena to which the public wished freedom of access—to modalities such as naturopathic treatments, herbal remedies, chelation therapy, shiatzu, reflexology and many others—

although many of these existed at the border of therapeutic legitimacy for traditional practitioners. The recent and successful lobby of herbalists against increased regulation of herbal remedies served to underline the public (and practitioner) argument that further restrictions were unwelcome for products which were centuries-old, popular, and relatively safe to use (*Edmonton Journal*, Oct, 4, 1997, A13). It was the view of several respondents that consumers should have access to these and other modalities and that government or professional authority should not be used to restrict these practices nor charge others with intrusion into exclusive jurisdictions. According to one respondent, so adamant was the public becoming in relation to the right to make choices that a wrong but informed choice was better than no choice.

Furthermore, several of the non-professional respondents described the increasing intolerance of the public towards professionals who maintained an isolationist approach to diagnosis and treatment. The public had come to expect collegial cooperation and teamwork amongst professionals to resolve health problems. No longer was it acceptable for patients to be required to fit into a 'box' of customary professional practice, uninfluenced by a broader range of possibilities.

While non-professional respondents extolled the need for greater public choice in health service, the professional respondents presented a different view. In fact, for them the term 'choice' was more confusing than enlightening. These respondents were in general agreement that what the public wanted was information from a professional concerning a choice of treatment and they wished to be involved as a participant in treatment decisions. However, professional respondents were confused by the often-heard reference to greater choice in service. In their view, there were many services which the public could choose to access, unencumbered by legislated restrictions. In a statement reflective of several, one respondent said, "I can't really think of other choices that they [public] would want" (NP7, p. 7).

Several of the nursing respondents suggested that the emphasis on greater choice, particularly evident in reports of the Health Workforce Rebalancing Committee, was so puzzling that the term was actually a euphemism for another intent. In their view, the intent was to remove exclusive practice legislation to enable employers to hire less costly staff, but under the guise of providing greater choice in service for the public. In disagreeing that greater choice in services was in fact being denied to the public, none of the respondents could recall from their practice any patient who had complained that exclusive practice legislative was excessively restrictive. Another suggested that at the public forums on health care conducted by the Health Workforce Rebalancing Committee which she attended, there was no mention of demand for greater choice, and that it was surprising to her to see this emphasis in reports from this committee. Since there are only summary records kept of the major themes discussed in these forums, it is difficult to determine the relationship between perspectives presented and personal agendas.

Nevertheless, professional respondents were more concerned with whether or not the public was a discriminating consumer. Several of the respondents felt that the public could not discern authentic and ethical practitioners, particularly in the alternative health field, from those who were incompetent. Several felt that it was in the public interest to be protected from costly, unproven treatment claims by charlatans who could be convincing, particularly to patients with chronic, unresolved symptoms.

Standardization of legislation. With the proliferation of health legislation since the 1970s, and speculation that more occupations would seek formal recognition, there was a general feeling amongst all respondents that the existing system of free-standing and umbrella legislation for twenty-nine health professions, each having 'different rules' was cumbersome and not given to easy interpretation by the public. Several indicated that the public was not interested in trying to decipher which professions had exclusive practice areas, and how these were interpreted between professional groups. What was of interest to the pubic was basic information about the practice area of each profession, how to access professional services and where to go if they had a complaint about the service they received. On these points, all of the professions agreed that this information should be readily available and understandable. Thus, for the most part, there was little opposition by the professions to the formation of one *Health Professions Act* as omnibus legislation inclusive of all the health disciplines and which was thought to encompass these principles. However, despite this agreement, professionals were sceptical that encompassing twenty-nine professional groups under one comprehensive act would solve the problem of complexity for the public.

There were a number of reasons which government bureaucrats identified as central to the need for legislative changes. First, there was a desire to depart from the tradition of each profession operating as though it existed in a separate 'silo' or legislative stall. This phenomenon was seen to be perpetuated by existing free-standing legislation and one which seemed to foster the continuous pursuit of greater status and exclusivity. Second, there was a desire to obtain some form of consistency in matters generic to all professions. Particularly in relation to complaint procedures, there was a need for "consistent, transparent, and user-friendly procedures" for investigating complaints from the public regarding the conduct of registered members (Government of Alberta, 1994, p. 20). This particular phrase was acknowledged by both nursing and government respondents as responsive to the public perception that professions protect their members when confronted with complaints. In addition, a standard procedure was necessary for appeals of decisions regarding complaints and discipline made by professional bodies. And the third rationale was the desire to have an easily understood framework for all regulated health professions, such that the public could understand the basic rudiments of self-governance and where to direct concerns.

Reduction of turf disputes. Another factor stimulating the elimination of exclusive scopes of practice was the perennial conflicts between professional groups. From the professional perspective, there was acknowledgment that professions were seen by government and employers as a costly component of health care service, exacerbated by the monopolies defined by exclusive practice legislation. This perception was not seen by nursing respondents as an accurate reflection of the nursing exclusive scope of practice, because the potential restrictiveness of the clause had never been applied to limit the practice of other disciplines. However, beyond this theme, there was little reference by these respondents to inter-professional disputes.

However, the non-professional respondents held a different but common view. From their experience, the public was frustrated with arguments from professionals about who had the right to provide which services. As one respondent indicated, the public believed that if the professions could not resolve these conflicts, then it was the responsibility of government to intervene. Since professions "did not talk to each other very much" (PP2, p. 5), the government had proceeded to establish umbrella legislation to better serve the public interest. The exclusivity of practice which, in the government view, was largely to "protect turf" was removed and replaced with a proposed list of restricted activities. The purpose was to eliminate the disputes inherent in mandating broad and exclusive jurisdictions, replacing that structure with a means to restrict certain practices to designated practitioners yet not exclusive to a particular professional group.

Additional factors. Although all respondents commented at length on the influence of manpower allocations, public choice and turf disputes as a collection of factors that were influential in the elimination of the nursing exclusive scope of practice, there were other factors mentioned by a smaller number of respondents which merit acknowledgment.

Two respondents, one with lengthy, but not current, government involvement and another with veteran experience in the nursing profession, both made reference to the current trend in government to remove itself from direct involvement in the regulatory functions of all professions. Both respondents referred to indications made public early in the mandate of the present government that the intent was "to get out of the business of providing service" (NP5, p. 19; PP2, p. 14). Beyond establishing policy to protect public safety and monitor monopolistic practices, there was a trend towards having professions manage their own affairs with as few regulations and restrictions as possible. Within this framework, the overriding purpose of all regulation continued to be protection of the public. Removal of the exclusive scopes of practice from all professional legislation was seen by these two respondents as very reflective of this trend, a trend which was referred to pejoratively by some professionals as 'deregulation' or 'deskilling.'

And, finally, three of the nursing respondents felt that the elimination of the nursing exclusive scope of practice was a reflection of an anti-intellectual, anti-elite, if not anti-feminist trend within the present government. The fact that the nursing profession was primarily female, with a significant number of well-educated leaders, did not fit, in the view of these respondents, with the 'populist, entrepreneurial trend which they perceived to be evident from government policy. Although these perceptions are difficult to verify, they are voiced in health and education arenas.

Expressed Positions of Stakeholders

The reaction of respondents to the proposed removal of the nursing exclusive scope of practice clause was based predictably on the personal and positional perspective of each interviewee. In keeping with these perspectives, the views of related groups of respondents were internally consistent but differed in some areas when contrasted with other groups of respondents. Thus, as was consistent with all discussions of proposed legislation changes, there were wide margins of variation amidst a few areas of consensus.

All of the nursing respondents disagreed with the proposed elimination of the nursing exclusive scope of practice clause as well as the replacement legislation of restricted activities. From their perspective, the extensive changes to professional legislation being undertaken were unnecessary. With the exception of changes reflective of greater transparency in the disciplinary process for all professions, it was their collective view that exclusive scopes of practice did not generate the barriers to manpower utilization which the government, and particularly employers, claimed. The most convincing argument in support of this view was made in relation to events which were occurring within the health system apparently unencumbered by existing exclusive legislation. As all of the nursing respondents pointed out, there had been many registered nursing positions deleted by employers, some of which were claimed to be replaced with less qualified workers, apparently unencumbered by existing legislation. It was this observation that led the registered nursing group to the conclusion that the government claim to legislative barriers to manpower utilization were not valid, at least in relation to nursing legislation—a fact, within the described circumstances, which could not be disputed.

The proposed elimination of the nursing exclusive scope of practice was met with a negative response by the registered nursing community. However, the factors contributing to that response varied. From the perspective of the Association, the assumption was that the proposed changes would not be overturned. It was a 'done deal' as several described it. The change was seen as a loss of professional identity, and as a loss of a distinction which had conferred professional status on the nursing community similar to other prestigious groups. The fact that exclusive practice areas were being eliminated from all health profession legislation was little comfort for this group in coming to terms with having to relinquish this most important, if only symbolic, status symbol. The introduction of restricted activities was also not supported by the Association. But perhaps of greater frustration was the belief that the exclusive scope of practice, at least as applied to nursing, was not creating barriers to manpower utilization as was claimed by government.

What was perhaps unfortunate was that this intended change was juxtaposed on other events occurring simultaneously which were also causing 'less than cheery' times for the Association and which, in combination, seemed to converge like a siege on the nursing community. It was a time when many registered nursing positions were being abolished or converted to part time positions, creating an unprecedented number of unemployed registered nurses. Those retaining positions were then faced with increasing workloads and also uncertain futures. This situation was further aggravated by the growing presence in the workplace of LPNs who were filling what had been registered nurse positions, and were performing 'advanced' functions made possible through enhanced training modules promoted by the PCLPN.

It was within the context of these events in the workplace, that staff nurses reacted to the elimination of the exclusive scope of practice. From their perspective, the purpose of the legislation was to ensure safe nursing services by registered nurses. In addition, it was also seen as a mechanism to protect registered nurse positions from encroachment by lesser qualified workers. When it seemed apparent to staff nurses that the Association was not willing to utilize the exclusive clause to resolve practice issues in relation to LPNs, they were seen to direct their frustration at the administrative staff of the Association who were seen to be representing them. There were, however, an unspecified number of staff nurses who, according to representatives of the United Nurses of Alberta and the Staff Nurses Association that went about their daily work, oblivious to the presence of or impact from existing nursing legislation. For this group, the elimination of this clause was seen to be a non-event.

Nor was the PCLPN an innocent bystander. They were critical of the Association for not having taken formal action against the apparent contravention of their Act, not by LPNs, but by nonregulated workers. In fact, the unregulated workers were encroaching on the jurisdiction of the LPN more than they were on the registered nurse domain. Had the AARN acted on their exclusive jurisdiction, the benefits to staff nurses would probably have been minimal, but significant for practical nurses.

The Association was fully aware of these dynamics occurring in the workplace and were also aware that the nursing exclusive scope of practice, with the exception of the medication clause, was legally not restrictive of anyone. It was for this reason that the clause had never been used to restrict the practice of others. Furthermore, it was recognized by staff members at the Association that because the PCLPN had their own legislation, they were accountable for the competency of their members. It was also not the role of the Association to 'do something' about the unprecedented job loss being experienced by their members. Their role was clear and involved the establishment of practice standards and accountability for the competence of members despite pressure from some factions of the membership to ameliorate employer-staff issues. What had become evident was that the proposed changes to health professional legislation signalled that no longer could nursing, or any other of the free-standing professions assume that their roles and positions in the workplace would remain the same. Inevitably, existing professions would endeavour to expand their scope of practice within the structure of the proposed legislation. Nursing was also seen to have the opportunity to advance into areas from which they were previously excluded. However, this process of change was viewed as requiring nurses to establish their position in the health field as a competent, cost-effective discipline on what was becoming a more level 'playing field.'

From the perspective of government respondents there was awareness of the nursing response to the proposed changes and acknowledgment that loss of jobs in the workplace contributed to their reaction. In their view, some of the professions interpreted the proposed changes to be punitive, particularly since there was considerable pride accorded to legislative achievements. However, the consensus from this group was that, other than issues arising in relation to medication administration, the impact of the nursing exclusive scope of practice had not been particularly remarkable because of the generic nature of the description. One respondent referring particularly to nursing, hinted that the proposed changes may in fact be changing 'things that work' (GP2, p. 20).

However, in the interests of uniformity across the professions, changes had to encompass all groups. The position of government respondents was that the intent was to promote minimum regulation to protect the public yet provide maximum flexibility in manpower allocation to employers. Issues of safety and liability presented by the professions as an argument in opposition to proposed legislation changes were seen by government respondents to be the responsibility of employers in relation to how staff were deployed.

PERSPECTIVES ON ALTERNATE POLICY SOLUTIONS

How the Proposed Changes Came About

A detailed description of events related to the proposed legislation changes were outlined in Chapter 4. From the perspectives of both the government and nursing respondents the formal statement of proposed changes to health profession legislation came about in early 1994 with the formation of the Health Workforce Rebalancing Committee. Shortly thereafter a discussion paper, "New Directions for Legislation Regulating the Health Professions," thought by some interviewees to have been prepared by bureaucrats, was released to stakeholder groups in Alberta. However, both groups acknowledged that an earlier paper, "Principles and Policies Governing Professional Legislation" in Alberta, released by government in 1990 was the real precursor to the proposed legislative changes. In that document, emphasis had been placed on professions voluntarily addressing issues of public accountability and transparency of regulatory processes in any future legislative changes they were proposing. Presumably, the fact that the voluntary changes called for in the policy statement had been disappointing, as one government respondent pointed out, prompted a more directive approach following the election in 1993.

Following the release of the discussion paper, a series of ten health care forums were held throughout the province. At the completion of the consultation process 3,500 people, representing professions, employers and members of the public, had been present at the forums, 300 written submissions had been received by the Committee and seventy-six organizations had made formal presentations. One of the nursing respondents claimed that she had been alerted to the pending changes in legislation prior to any 'official' government announcement. Assuming that there was some validity to the information, the Association prepared a response in anticipation of a need to make a formal presentation if a consultation process was announced by government, as it later was. According to nursing and government respondents there was considerable professional opposition to the document evident early into the consultation process. One of the interviewees suggested this early opposition was indicative of preparatory work by some of the professions who had 'advance' notice of the government agenda. It was also suggested that because some of the professions had had time to prepare their opposition, this may have added years to projected time lines for legislative changes. Whether this observation was true was not confirmed; however, the most contentious issues presented by the professions to the Committee were related to mandatory registration, exclusive practice clauses, restricted activities, and the proposed Health Professions Board, essentially the core elements of the discussion paper.

With the release of a revised document, Discussion Paper II, more written submissions were received and more in-person presentations were made. One year later a final report was released and a steering committee of government bureaucrats was established to implement the report. Since then a number of subcommittees have been established to direct the implementation of key elements in the report. One of the early subcommittees established was the Advisory Committee on Restricted Activities. According to two of the government interviewees, there was extensive consultation in relation to restricted activities. Although there was no consensus on which professional activities should be restricted, the completed document as of October, 1997 was a reflection of the proposed restricted activities which appeared to have the most support amongst the professional groups, and the related rationale. What is not complete is the determination of which professional groups will be authorized to perform designated restricted activities. Other subcommittees continue with their consultative process. The proposed deadline of Spring, 1999 for the completion of all aspects of the restricted activity component is, according to government sources, optimistic. The summation of comments of the government and nursing respondents indicated that the overall process had resulted in ample consultation but little consensus.

The Meaning for the Nursing Profession of Eliminating the Exclusive Scope of Practice Clause

What was evident from the nursing respondents was that the exclusive scope of practice clause had become symbolic of the ultimate professional achievement, that of a self-governing body with responsibility for a distinct area of practice. At the time the legislation was enacted it was considered prestigious for a professional association to have its own Act, rather than being absorbed with other 'secondary' health professions under omnibus or non-self-governing legislation. It was considered to be even more prestigious for the nursing profession to have a defined exclusive scope of practice, a privilege which had not been achieved by all of the self-governing groups. From the nursing association perspective, the exclusive legislation was viewed as the ultimate assurance to the public that a quality nursing service was being provided, since only those who were qualified could deliver nursing services. From the perspective of the membership, the exclusive scope of practice was considered to provide employment security, a belief which proved to be false as health care dollars diminished. And all of these desiderata had been achieved after a period of approximately ten years of lobbying efforts with government, as well as sustained internal efforts to ensure that a large and diverse membership was informed and supportive of the phrasing of the legislation as well as the companion mandatory registration clause. Thus, as someone suggested, the nursing exclusive scope of practice had 'adorned the professional mantle' for over a decade as the result of a successfully orchestrated strategy. To suggest that it would be given up with ease was naive.

However, although the Association claimed that exclusive practice legislation would achieve all of these potential benefits for the membership and to the public, the reality was different. There was evidence of incompetent practice. There was evidence that the public could not necessarily be assured of quality service and there was evidence that job security was not a reality despite the existence of the exclusive jurisdiction. It was clear that the utility of the legislation was inconsistent with the symbolism it had come to represent. Yet, a strong perception persisted, particularly amongst the membership, and in the face of contrary fact, that the existing legislation provided a legitimacy to the profession and somehow protected the jurisdiction from unwelcome changes in the external environment.

What became confusing in discussions with nursing respondents was that although several felt the elimination of the nursing exclusive scope of practice would not have a significant effect on the profession itself, the subsequent discussion was inconsistent with this belief. There were lengthy and emotional descriptions and predictions of the effect eliminating the exclusive practice clause would have on the profession as well as the public. What was apparent from the seemingly contradictory discussions was that, on the one hand, the description of nursing practice, as defined in the exclusive practice clause, seemed to amply reflect the nursing domain, and more importantly, provided a professional identity. As one interviewee pointed out, "It served us well" (NP3, p. 19). On the other hand, participants acknowledged that, in reality, the exclusive clause had never provided the clarity required to distinguish what nurses did as distinct from the role of other disciplines. Thus, it seemed that the historic pursuit of definition by the Association had been reawakened, now more urgently, when it was faced with eliminating legislation which had provided a degree of definition, albeit not particularly distinctive.

One of the primary concerns of the nursing respondents was that mandatory registration would be eliminated along with the exclusive scope of practice. Without mandatory registration, there was fear that the number of members choosing to register would decline, particularly as part time employment increased. It was also assumed that individuals with questionable work histories would choose not to register, thus eliminating the possibility of sanction from the licensing body. Furthermore, the Association was seeing an overall trend in government to 'deregulation,' which, when applied to professional legislation, would allow employers the option of hiring less qualified, less costly workers. Thus the two legislation provisions, that of an exclusive jurisdiction and mandatory registration, were the two most important means by which the Association could monitor practice standards and assure the public that service providers were competent practitioners.

Although mandatory registration was of particular concern to the Association, it was clear that the future role of the LPN was of equal concern. All of the nursing respondent were convinced that with the elimination of the nursing exclusive scope of practice, there would be increasing evidence of LPNs assuming many of the traditional functions of the RN. This concern was exacerbated by the belief that if registered nurses could not define an area of practice which did not significantly overlap with other disciplines, there was a significant likelihood that other groups, particularly LPNs, would be welcomed by employers to assume the RN role, particularly if they could do so at less cost. In fact, government respondents verified this fear. Their impression was that the LPNs had positioned themselves favourably with employers who had been convinced that this group of worker was cost effective and could assume a greater portion of the RN role.

The argument that LPNs were a cost-effective alternative to registered nurses was questioned by the nursing respondents. The baccalaureate-prepared nurse had long been considered by the Association as the most cost-effective and efficient of nursing care providers. This individual was seen to have a broad base of skills to provide direct care in acute care facilities or community-based practice without the requirement of direct supervision. However, if LPNs were to become more prominent as direct providers, the implication was that the 'degree' nurse would then assume the role of care coordinator. While this was considered an appropriate role, this individual would likely be removed from direct care provision, a change which the Association, the nursing unions, and apparently the membership were not in agreement with. The concern with this role change for registered nurses, then, was two-fold. Ultimately, the effect of employing less skilled workers would result in a lower quality service to the public and, in some instances, less safe practice. Furthermore, there already existed a cost-effective, well-trained registered nurse whose role was being mimicked by the PCLPN, but without the breadth of educational background or practice versatility.

The concerns discussed at length by the nursing respondents in relation to the removal of the exclusive practice clause were largely confirmed by the government respondents. It was their collective view that much of the direct nursing care would be provided by LPNs. This group was seen to have the required basic skills and were more cost-effective than the registered nurse. The baccalaureate-prepared nurse was seen to be performing many of the same functions as the diploma nurse. This group of respondents predicted that the 'shifting upwards' of professional roles, as was evident in all professions, would similarly affect the future role of the baccalaureate nurse. Thus, this level of nurse would assume the responsibility for the supervision and coordination of much of the direct care activity, allowing lesser skilled and less costly workers to provide the basic direct care.

Although this role transition represented a trend well known to the nursing community, nursing respondents expressed various views on the speed with which this might take place, if at all, and the extent of the overall impact on service delivery. Several of the nursing respondents were mindful of the fact that although there had been great initial concern with LPNs administering medications, there was not, in fact, widespread evidence of this actually happening in Alberta facilities some ten years after this aspect of exclusivity was removed from nursing legislation. One of the respondents who, as a member of the Health Workforce Rebalancing Committee, had heard and read all of the submissions to the committee, felt that although the role of the LPN would tilt towards direct care, "nurses will reign supreme . . . because they have their team stationed at all the doorways" (GP2, p. 18). He confirmed that this was not a negative description, but rather a conclusion which he and some of his colleagues had come to based on their belief that the nursing exclusive scope of practice was much less of a barrier to other disciplines than was originally thought. In the future, he felt that registered nurses would continue to "come out more or less on top of things" with the LPN assuming more responsibility for direct care, yet remaining in a complementary role to registered nurses as the coordinator of services (GP2, p. 19).

However, not all LPNs were happy with the prediction that their role would be expanded. Although it was not clear how widespread was the feeling, some members of this group were not happy with the direction that the PCLPN was taking in offering advanced courses in medication administration and more intensive clinical areas (NP1, p. 19). It was known that the intent would be to incorporate these advanced skill areas, and probably others to be developed, into the basic program. With additional skill came additional responsibility. It was the position of at least some of the PCLPN membership that additional responsibility was not welcomed. The comments to one of the nursing respondents was that "if I had wanted to assume more responsibility, I would have trained as a registered nurse" (NP1, p. 19). Also with increased responsibility came the desire to be fairly remunerated. These same LPNs were also suggesting that if they were required to assume more responsibility, then they should be paid accordingly, that is, similar to the diploma nurse, if the roles were similar. Thus, in the future, as two interviewees noted, the LPN may not be as cost-effective as was originally thought, or the salary differential between the two categories of workers may not warrant hiring a less qualified practitioner.

Although the role of subsidiary workers was very central to the meaning which eliminating the exclusive practice clause had for the nursing profession, there was some optimism about the future role of the registered nurse. With the removal of the medical exclusive scope of practice, there was a sense that nurses would be able to assume roles which had previously been reserved for medical practitioners. For other respondents, this potentially enhanced role did not imply a new training requirement, but rather reflected knowledge and skills already acquired which had been under-utilized. In essence, from this latter perspective, the implication was that the extended role was very similar to what would be the scope of practice for all nurses, thus allowing for much more independent practice.

Government respondents seemed particularly supportive of nurses moving into expanded practice areas. They spoke of the futuristic role of community health centers and the shift away from what was a medically-dominated system to one in which there would be expanded opportunities for groups of professionals to work in a collaborative practice. Nurses who were seen to be most valued in this anticipated model of health care delivery were those with a clinical master's preparation or those already enrolled in an advanced practice program at Athabasca University. It was on this latter point of desired credentials that the nursing unions were cautious. While they supported the potential for advanced practice, it was their view that the opportunities would only apply to a small number of nurses. For the most part, their 19,000 members, most of whom were diploma-prepared nurses, would not meet the qualifications. Thus, as several of the respondents acknowledged, the nursing workforce in the future was projected to be smaller, but more skilled, thus leaving the largely unanswered question of the continuing role of the diploma prepared nurse.

Potential Resolution of the Issue of Barriers Between Professions

The discussion surrounding the question of whether eliminating the nursing exclusive scope of practice would reduce the barriers between professional groups generated, as had other discussions, widely diverging viewpoints. Although the exclusive practice component of existing legislation was central to the discussion, it was apparent that respondents were compelled to make reference to all of the proposed legislation changes rather than singling out one component. The comments ranged from a prediction that there would be very little change, to a guarded optimism, if not veiled hope, that in fact legislative changes would result in fewer boundaries between professional groups. No one was willing to state, with confidence, that the new legislation would solve the problem of reducing barriers between the professions. The most optimistic suggested that legislative changes would only be realized in practice if there were other, more fundamental transitions within the profession of nursing and within existing payment structures. This form of contingency theorizing was perhaps wise given an impenetrable history of professional resilience and endurance when faced with jurisdictional intrusion.

From the nursing perspective, there was a belief that eliminating the nursing exclusive scope of practice was based on the false belief that it promoted turf protection between the professions. This was a perception seen to be widely held by the public and one which, according to the nursing respondents, required greater clarity of understanding rather than "dismantling all the professions" (NP3, p. 24). It was the feeling of this group that professions could co-exist within their exclusive jurisdictions without limiting the scope of other groups. This seemingly contradictory belief could only be interpreted to refer to the LPN group with their exemption from nursing legislation.

In focusing on the nursing exclusive scope of practice, all of the nursing respondents rejected the notion that this legislation had been restrictive of other disciplines. Although at first glance this seemed to imply that the problems were "not in our back yard" there was some truth to this perception. This group was accurate when they pointed to the fact that the nursing exclusive scope clause was so general that it could not be interpreted, nor had it ever been utilized, as a restriction on the practice of others. That it was a generic description and could never seem to be redefined to distinguish nursing practice from other disciplines had plagued the nursing community and baffled the 'best minds' for years.

Nursing respondents were sceptical that removing the exclusive scopes of practice would remove barriers between the traditional professions. Some respondents felt that, in fact, such a change could increase interdisciplinary struggles. The feeling was that most of the turf issues occurred at the policy level of the various professional associations. At the level of the practitioner working in the field, there was seen to be a considerable degree of collaboration. The fear was that the introduction of 'restricted acts' to replace exclusive scopes of practice would stimulate jurisdictional competitiveness amongst practitioners as to who could provide which services and thus would, in fact, generate unnecessary suspicion and controversy.

In looking outward from the nursing community to other disciplines, several of the respondents pointed to recent circumstances where nurses had been authorized to practice in areas outside of their traditional practice area. Through amendments to the Public Health Act, nurses had recently obtained the authority to provide what had traditionally been medical services in remote areas of the province. This change had occurred despite the fact that exclusive scopes of practice (namely, the physician exclusive scope of practice) existed within legislation, suggesting that contingent on circumstances, exclusionary practices could be altered. A similar situation occurred in which midwives were given the authority to practice (but were not publicly funded), also at a time when such activity was the purview of physicians. The discussion, particularly in relation to midwives, was highlighted by nursing respondents in making the point that removing exclusive scope of practice would not be a sufficient change, of itself, to remove barriers to practice areas. Thus, as was the case of midwives, although jurisdictional exclusivity (physicians) had been overcome, there remained barriers to practice because of lack of public funding arrangements. A number of respondents felt that funding structures were of equal significance to exclusive jurisdictions in erecting barriers to alternate service delivery. That is, if a professional was authorized to provide 'additional' services, yet not funded, very little would change in the health system.

Quick solutions to funding formulas were not likely to be found soon. Of the two options, that of fee-for-service or reimbursement through institution-based budgets, neither seemed expedient. In the former case, government was not interested in compounding an already existing problem. In the latter case, employers were not speeding to make further commitments on already overextended budgets. It was circumstances like these which several respondents referred to in suggesting that removing exclusive scopes of practice may not substantially change the relationships between professional groups. These were examples which several respondents felt reflected political rather than legislative barriers. Some suggested that until government had the political will to fund services, barriers to the utilization of a variety of health professions would remain. The proof that there was a serious attempt to reduce the barriers between professions, according to one interviewee, would be in the funding allocation.

Several of the nursing respondents were concerned with the proposed list of restricted activities from two perspectives. First, it was believed that in restricting a list of activities to designated practitioners, there were large professional practice areas outside of the restrictions which now could be performed by any practitioner. The concern here was that many of the practices not proposed as restricted, could result in harm if performed by incompetent practitioners. Government respondents were not particularly supportive of this viewpoint. It was their view that the exclusive scopes of practice had been excessively restrictive when in fact many aspects of professional practice could be carried out safely and at less cost by other workers than was presently the case.

This concern with practice areas proposed as no longer restricted to specific professional groups led to a second concern for the nursing respondents and one which was acknowledged by one of the government respondents. The prediction of the nursing respondents was that the removal of the exclusive jurisdictions would in fact encourage the emergence of new groups who would press for recognition and contribute to turf disputes. From the government perspective, and also noted by one of the public respondents, the phenomenon of groups identifying a field of practice, organizing as a professional body, and 'bumping up' an area of practice was an evolutionary process common to all professional groups. This was a well known phenomenon, and one which for many professions was the natural, and somewhat expected outcome, of changes in technology and expanded educational programs. What was of particular concern for the government respondent was the likelihood that bureaucrats would be unsuccessful in their attempts to prevent the large groups of presently unregulated aide-level workers from organizing, forming or joining a union and pressing for financial recognition, largely because of strenuous pressure group activity.

Having discussed their specific concerns related to removal of barriers between professions, respondents seemed compelled to step back from the specific concerns and to assume an 'armchair spectator' stance in their conceptualization of professions, regulations, and barriers. It was as though each respondent wished to summarize his or her own thoughts by bringing forward a 'world view' which they had not previously been able to communicate. The discussion inevitably addressed the last question on the interview schedule which referred to alternate policy solutions. Although the integration of the two themes seemed logical from the perspective of the respondents, for the purpose of reporting each are described separately.

From this broader perspective, there was a recognizable hesitancy on the part of all respondents in suggesting that removing exclusive scopes of practice from professional legislation would bring about a significant change in the barriers between professional groups. Without exception, all respondents, some more vociferous than others, concluded that there were many more factors sustaining barriers between professions than those resulting from exclusive practice legislation. Professions had been methodically structured on an ideology of prestige, exclusiveness, and distinctiveness. To suggest that 'simple' changes in legislation would suddenly and significantly alter these traditions was to mistakenly view legislative changes as a panacea. After all, as one respondent pointed out, the original and enduring purpose of professional legislation was to protect the public. However, what was seen to have emerged was a collection of attitudes and political postures, all of which had very little to do with legislation. Furthermore, in relation to this role, there was also a long tradition of some professions having more influence than others, a reality seen as unlikely to change significantly. Thus, the collective view seemed to be that although it was possible to engineer a variety of legislative changes, in the final analysis the relationships between groups was largely dependent on attitudes and politics.

Perhaps it was this insight, though hardly a revelation, that led to a more tempered view of the future. Several of the respondents who had been directly involved in the proposed legislative changes, admitted that they were having difficulty visualizing what the future would look like after a new Health Professions Act was enacted. And the Ontario experience was not one which was expected to provide a preview any time soon of what a supposedly clearer vision might include. The enactment of their *Regulated Health Profession Act* had occurred in 1989. Almost a decade later, according to government sources, many professional regulations were incomplete.

Thus, with very little, if any, legislation models in other jurisdictions, the future of the proposed legislation and the eventual outcomes were largely speculative. As was implied by several respondents, one of the members of the Health Workforce Rebalancing Committee indicated that he had concluded that the idea of "barriers between professions had been overstated" (GP2, p. 22). He was of the view that there would be eventual changes in professional scopes of practice with or without the presence of exclusive legislation. These changes, he predicted, would take place partly because of the assertiveness of groups like nursing and partly because of recognition that there were areas of practice in all the professions which could be exercised safely by less costly workers.

In putting the proposed legislative changes and eventual outcome in perspective, a government interviewee wanted to make it clear that these changes were a reflection of the times. Although present discussions of barriers between health professions "had a nice ring to it," much of the existing legislation was a product of the 1980s and was not in keeping with changes in the health field (GP2, p. 22). Exclusiveness, at the time, had been 'fashionable.' However, times had changed. There were many more professional groups and there was much more evidence of overlapping scopes of practice. There was also a perception that government should have much less control over the governance of the professions, and in fact less overall regulatory power. He speculated, as did other respondents, that whatever legislation was enacted would reflect more 'flexibility.' However, he cautioned, as did many of the nursing respondents, that with greater flexibility as to who could perform which functions, there was concomitant risk for consumers. His prediction was that if complaints and lawsuits ensued, the pendulum would swing back in favour of increased professional restrictions. But, for now, there would be a period of calm, there would be less exclusiveness, and there would be greater expectations within and between all groups for cooperation and collaboration.

Alternative Policy Solutions

It was evident from the respondents that there were few policy alternatives which could be specifically identified and described as superior to that which was already proposed. Part of this response seemed to reflect a disinclination, particularly by the nursing respondents, to expend a great deal of time formulating an alternative solution when the current exclusive scopes of practice were not seen to be significantly problematic to warrant a lengthy process of reform. The government respondents had all been instrumental in various phases of the proposed changes and were cautiously optimistic that the overall direction was appropriate in relation to the information that was known. Thus, it was not surprising that they did not offer recommendations related to revising the present policy direction.

Given the extensive background in professional arenas, and lengthy and senior involvement in policy development, it was anticipated that the respondents would have been able to at least provide some alternative direction, albeit conceptual, to the present policy direction. Perhaps the fact that this did not occur reflects several factors. First, it was clear from the comments of several respondents that the solutions to reducing barriers between professional groups did not reside in new policy directions. The comment was frequently made that "you can't legislate cooperation or collaboration." The inference was that irrespective of what the legislation stated, if professions were not willing to work together, there was a litany of examples to indicate that means would be found to circumvent unsupported policy directions. Second, there are no alternative policy solutions in other Canadian jurisdictions which are significantly different from the proposed changes in Alberta. The most 'advanced' changes in health profession legislation have been made in Ontario, with other provinces following a similar approach but not as far advanced into the change process as Alberta.

Nevertheless, despite a paucity of alternative policy directions, there were a number of themes which respondents felt had particular importance, either specifically to the nursing profession or in relation to inter-professional relationships. Mandatory registration was seen by the nursing respondents to be extremely important from the perspective of maintaining the only means by which their association, or any of the other professional organizations, could continue to monitor professional practice and assure the competence of their members. In the early discussions with the Health Workforce Rebalancing Committee, the nursing respondents assumed that with the deletion of the exclusive scope of practice, mandatory registration would also be eliminated. This potential outcome was challenged by most of the professions, with the outcome that mandatory registration is likely to be retained and applied to all professional groups.

Several of the nursing respondents have indicated their support for uniformity across disciplines in relation to professional conduct and disciplinary procedures. One of the original objectives of the proposed changes was to establish a common professional review process administered by a health professions board for all of the professions and one which, because of its commonality, could be communicated easily to the public. The Health Disciplines Board which had provided a unifying structure for those groups under the Health Disciplines Act was seen to be a useful model. According to the interviewee representing the PCLPN, this Board was supported by the majority of the governed groups. However, although the concept of uniformity across disciplines was supported by several of the nursing respondents, they did not support the concept of a health professions board.

A second theme related to the existing fee-for-service structure. The discussion was general, brief and terse as to what the future direction should be. Several of the respondents felt that attention by government to professional fee schedules was critical to the removal of barriers between professions. Although removing legal restrictions on who could provide which services was one step towards greater collegiality between the professions, the means of remuneration as it presently existed was obstructive, particularly as applied to physicians and nurses. As one of the public respondents pointed out, as long as nurse practitioners were paid from the income of physicians, there would be little incentive to hire this category of worker, particularly at a time of estimated physician surplus, despite overwhelming evidence supportive of this collaborative model of health service. One of the respondents suggested that if physicians were paid on a 'salaried' basis there would be "massive" and immediate positive changes in problems of service access and collegiality (PP2, p. 11). Added to this projection was another definitive view that "with different methods of reward and incentives, the collaborative team process will commence" (PP3, p. 13)

A fourth theme related to the ways in which health professional education was organized. As was best described by one respondent, "We've divided everything up into these funny boxes, like silos, traditionally going back probably a hundred years" (PP2,

p. 13). This statement was made in reference to the separate faculties of health-related disciplines, and the relatedness of this phenomenon to the exclusivity in professional legislation. The recommendation was that collaboration between professional disciplines would be enhanced if there was greater integration within the training process. Although not a new idea, it was one acknowledged to have merit in promoting professional collaboration, but also great resistance, given the prestige and exclusivity attached to certain faculties. One of the respondents, in speaking from an educational perspective, endorsed the need for programs to encompass greater acceptance of overlapping roles in all the professions. Educational programs, in her view, had become too "isolationist" while still expecting that students would somehow be able to function as part of an interdisciplinary team when they graduated (NP2, p. 13). The challenge was to teach students how to function in what were likely to remain the 'grey areas' of overlapping professional practice.

The last theme, and one which prompted the most discussion, was that of continued competence. Most of the respondents, though not necessarily in agreement with the proposed change, acknowledged that exclusive practice areas were 'gone' and, along with it, the era in which professional groups could maintain tight controls over clinical jurisdictions. It was the belief of nursing and government respondents that attention to what was exclusive to a jurisdiction needed to shift to the internal development of the profession itself, given a changing environment. The future of nursing and other professions was seen to be much more dependent on the assurance of initial and continued competence rather than depending on policy statements, credential requirements and jurisdictional regulations to ensure a place in the workforce.

Although the issue of continued competence had long been a discussion point for the nursing profession, as well as others, mechanisms had not been established to ensure an ongoing evaluation process. All of the professional associations had established standards for entry into the practice of the profession. However, once the member was employed, the employer was relied on to ensure that staff continued to be competent to practice. The requirement in the future, according to government respondents, was that professional associations would need to implement a continuing competency program. The problem that was acknowledged was how this could be done in a way that was effective yet cost-efficient. Furthermore, the questions of whether competency should apply to general areas of the scope of practice or only to specific employment areas were seen to be complex and had implications for manpower utilization as well continuing education requirements. Nevertheless, despite the sizable task ahead for all the professions, it was acknowledged by several respondents that it would become much more central to the future role of professional organizations.

One of the nursing respondents best articulated what several had implied. Maintaining a competent workforce in all of the professions was the critical factor which she predicted would become the central force in protecting the public and a more viable alternative to exclusive jurisdictions. It was her contention that the future of nursing was contingent on the ability of the practitioners to provide "good, competent, professional, economic nursing services throughout the province" (NP4, p. 30). Because of the inherently broad and non-specific scope of practice, there was evidence that many nursing functions could be shifted to less costly workers. Inherent to the future of all professions was the necessity to provide evidence to employers that professionals were competent, cost efficient and willing to work as part of a health care team rather than perpetuating isolationism and exclusivity.

CHAPTER 8

THE LAST CHAPTER:

A CONVERSATION WITH YOU, THE READER

This chapter is addressed primarily to those who have a special interest in, and knowledge of, health profession legislation, namely health professionals and policy makers. In order to place this chapter in context, the first section includes a brief overview of the study intent and design. The second section is a discussion of circumstances which became apparent as the study progressed, and which inevitably impinged on the initial study objectives. The last section deviates in style from the second section and is presented in the form of an 'open letter,' first, to all health professionals, second to the nursing profession, and finally to policy makers. This last section is the composite of the scholarly reflections accumulated in the course of this journey.

AN OVERVIEW OF THE JOURNEY

This study was conducted as a prospective policy analysis to determine if eliminating the exclusive practice clause from the Nursing Profession Act is a feasible policy solution to the perceived need to decrease barriers to the provision of professional health services, or if other solutions are more desirable and feasible. The intents of the study were to describe the historical background and present status of the public policy issue of eliminating the exclusive practice clause from the *Nursing Profession Act* in Alberta; to explore the desirability and feasibility of eliminating this clause as one means of working towards decreasing barriers between health profession groups; to identify alternative approaches or policy solutions to the proposed legislative change acceptable to stakeholders; and to provide recommendations for policy formation based on these findings.

The study addressed the following questions and sub-questions:

1. What is the history of exclusive scope of practice legislation as applied to nurses and related paraprofessional groups in Alberta?
    - a. When did exclusive scope of practice legislation first become a policy issue?
    - b. Who promoted exclusive scope of practice legislation and why?
    - c. Historically, what have been the expressed positions of stakeholders in relation to exclusive practice legislation and why?
2. Is the proposed strategy to eliminate exclusive practice legislation a feasible or desirable policy to remove barriers to delivery of services?
    - a. Is there a need to increase access to service delivery?
    - b. What factors are contributing to the increased demand for changes in legislation?
    - c. What are the expressed positions of various stakeholders?
    - d. Why do stakeholders hold these positions?
3. What alternatives to the proposed legislative changes do stakeholders perceive as desirable and feasible ?
    - a. To what extent do stakeholders support the proposed policy changes?
    - b. Are there other policy solutions which could resolve this issue?
    - c. Why do stakeholders hold these positions?
    - d. What factors affect resolution of this issue?

Research Design and Process

In order to place the study in perspective, an extensive review of the literature was conducted. This review established that health profession legislation, from an economic, political and social perspective, has been an enduring and controversial issue for professionals and policy makers in every Canadian province. From a macro-view, a large part of the controversy surrounds the proliferation of health professions, particularly those with exclusive practice jurisdictions, and the related impact on the cost and delivery of health services.

Current issues are steeped in historical developments. The model of professionalism which emerged around the turn of the century has remained largely unchanged to the present day: expertise obtained by university education, a commitment to the public welfare, and dedication to the interests of patients. Based on this profile, professional groups have been granted enormous discretionary authority by legislatures in Canada to set and enforce standards of practice and to define those services which their members have the exclusive right to perform. Conversely, the power of self-government has hastened the pursuit of professional status by non-regulated practitioners. Juxtaposed with the continuous pressures on governments for new or revised professional legislation is the coalescence of factors challenging the wisdom of self-governing regimes: rising health care costs, barriers to the delivery of health services, inefficient utilization of competent practitioners, increasing consumer demand for choice in health service, and charges of professional self-interest and monopolistic practices.

Beginning in the 1960s, governments have been engaged in attempts to institute changes in health profession legislation. This virtually continuous exercise originated with the adoption of government-sponsored health insurance, establishing provincial governments as the major cost-bearers of health care. All of the subsequent health profession legislation review processes have focused on one or more of the following concerns, each commensurate with a particular historical moment: restrictions on entry to practice particularly when public consumption of insured services was projected to increase, profession-controlled complaints procedures increasingly unacceptable to an emerging consumer movement, and professionally-defined restrictions on service provision in the face of escalating health care costs. Recommendations which emerged from these review processes focused largely on the structures and processes of professional regulation, inclusion of public representation on professional governing councils, cabinet approval of regulations, improved appeal mechanisms, separation of professional and economic interests, and required delegation of tasks to other disciplines. Since few of these recommendations were fully implemented it seemed that professional groups had successfully thwarted any substantive efforts to implement change (Tuohy, 1986).

In more recent years, there have been renewed attempts to grapple with health costs and the barriers to the provision of cost effective services generated by exclusive professional jurisdictions. Governments have deviated significantly from older models of professional legislation, embracing the notion that, first, only a small number of activities performed in health care place the public at serious risk and, second, that it is regulation of the performance of these acts, not the regulation of the professions themselves, that constitutes the legitimate use of government regulatory responsibility. Thus contemporary models of health profession legislation have replaced exclusive scopes of practice with a list of restricted activities which only designated practitioners are allowed to perform. In theory, this model is intended to offer greater regulatory flexibility and discretion in the delivery of health services.

A conceptual framework for prospective policy analysis of the issue of eliminating the exclusive scope of practice from the Nursing Profession Act in Alberta was utilized. This framework incorporated aspects of Dunn's Model of Policy Systems (1981). The framework utilized a qualitative case study technique to describe and analyse the perspectives and positions of identified key stakeholders regarding the issue of eliminating exclusive scopes of practice. The framework specified three components: the policy environment describes the social, economic and political context in which professional legislation has been imbedded; public policies included those commissions and reviews which have been influential in the decisions made by government in response to this issue; and, finally, policy stakeholders includes a description of the issue as viewed by study participants, analysis of the issue, and development of policy perspectives and recommendations. The framework was of assistance in directing the study process, particularly in defining data requirements. Given the quantity and diversity of available data, the framework was also of assistance in completing the study.

Seven participants representing the nursing profession, one representative from the Professional Council of Licensed Practical Nurses, three representatives from the Departments of Health, Labour, and Advanced Education and Career Development, and three participants representing a public perspective were selected as the key stakeholders in this issue. Participants from the nursing profession and the Professional Council of Licensed Practical Nurses were selected through criterion-referenced sampling. The criteria used in this selection were: participants were established members of the nursing profession and appeared to have considerable influence on policy development; participants were familiar with health profession regulation and had been involved in previous changes in nursing legislation and regulation; and participants represented a variety of backgrounds and extensive experience in one or more fields of administration, nursing service, nursing unions, and education. Representatives from the Departments of Health, Labour, and Advanced Education and Career Development were identified as essential for inclusion in the study based on the responsibility of these departments for revisions to health profession legislation. Interviewees in each of the departments were selected by a process of purposive sampling, based on identification of the most knowledgeable and accepted spokesperson in each area. Inclusion of participants representing the public interest was also considered essential to gain a comprehensive view from the perspective of a consumer of health services. These participants were chosen on the basis of their knowledge of health profession legislation, arms-length or no current involvement in professional legislation policy development, and their ability to articulate the interests of those receiving health care services. In the final analysis, the participant group of three interviewees was simply limited by availability of the interviewee and the time-constraints associated with completing the study.

Data collection was also carried out through document analysis prior to, concurrently, and following the interview process. Documents included government policy papers, health profession acts and regulations, reports, commissioned reviews, minutes of meetings, correspondence, published and unpublished position papers, newspaper articles, published journal articles and books related to the issue of health profession legislation and professionalism. Pilot interviews were conducted prior to commencing the interviews. Taped interviews were conducted in four phases: nursing profession respondents, licensed practical nurse respondent, Departments of Health, Labour, and Advanced Education and Career Development respondents, and finally respondents representing the public interest. A semistructured interview format was used to ensure that perspectives or points of variance or controversy identified in previous interviews could be discussed. Content analysis and comparative analysis procedures were used in analysis of both the document and interview findings. Categories for data recording and analysis were based on the conceptual framework and the research questions. External audits of the data collection procedures, categorizing of responses, and interpretation and reporting of findings were conducted throughout the study. Interviewees gave permission for transcribed information to be used for data analysis with the caveat that the interviewee not be named and that reasonable means be applied to disguise identification by association.

The analysis of the data and the development of recommendations were conducted according to the conceptual framework and included the history and current status of health professional regulation, the context of proposed changes in legislation and the positions held by various stakeholders. The description of the issue and the beliefs, assumptions, and facts evident in the stakeholder perceptions regarding the elimination of the exclusive scope of practice clause were identified. The similarities and conflicts evident in the stakeholder perspectives as to the desirability and feasibility of eliminating the exclusive practice legislation were explored. Alternatives to proposed policy changes were sought from stakeholders and analysed in accordance with views of participants. The conclusions from the findings, presented in the form of scholarly reflections, were based on interviews and reviews of literature and documents.

Measures to ensure validity and reliability of the study included triangulation, external audits, and provision of detailed descriptions of the context of the study, stakeholder perspectives, and the research processes. Recommendations unfolded as context-bound reflections evolving from an in-depth understanding of the issues rather than a series of generalizable truths or theories. Formal consent to use the interview data and assurance of anonymity and confidentiality other than as specifically approved by the interviewee were the major measures used to address the ethical concerns.

On Glancing Back

During the course of dissertation research, it is inevitable that events will occur, or circumstances will arise, which impinge on the study trajectory and which could not be anticipated at the outset. Thus, on reflection, and in the spirit of case study research, it is customary to describe to the reader those circumstances, largely unanticipated, which were operational as this study evolved. To do so serves a dual purpose. It serves as a reminder of the shifting nature of policy environments and provides a richer contextual view of the circumstances influencing the responses of participants.

Limitations on the Literature Review

One of the difficulties which I experienced was determining boundaries to the literature review, particularly in relation to historical antecedents. The challenge became one of trying to distill a large body of literature in a concise and informative way, yet remaining cognizant of the risks of glossing over significant historical developments. The literature on professions proved to be bountiful, depicting as it did a sociological obsession with the theoretical underpinnings of professions and professionalism. However, there was no neatly packaged, universally recognized description of what constituted a profession. One of the most light-hearted, but nevertheless insightful conclusions was advanced by Gross (1977) who, having undertaken a similar review, concluded that no one really knew what a professional was, yet everyone wanted to be one. In the final analysis, my decision was to include the most prominent of viewpoints in an attempt to place contemporary professional ideology within an historical context.

The same challenge existed in relation to provincial reviews of health profession legislation. Every Canadian province has tackled this issue by means of at least one formal review process, and usually more. Unlike the conceptualization of professions, this body of literature reflects remarkable congruency in relation to concerns and recommendations. This finding, along with a necessary decision to condense the potential volume of information led to the decision to limit the inclusion of historical health profession legislation reviews to the provinces of Alberta, Ontario and Quebec. Both of these latter provinces had undergone a series of well-known commissioned reviews, and were considered to be 'flagship' provinces in their recommendations for legislative reform. Although the provinces of British Columbia, Saskatchewan and Manitoba have also undertaken reviews of their regulated health professions with an apparent interest in the

Ontario model, these groups appear to be in a 'wait and see' mode and therefore were not included.

Alternative Policy Directions

One of the intended outcomes of the study was to explore alternate means to eliminating practice barriers between professions and to conclude with the 'one best solution' potentially attractive to a number of professions. This did not happen. Early into the data collection phase of the study, it became apparent that alternatives to the proposed model of health profession legislation were not evident. Although the reasons for this differed according to participant groups, this response, particularly by the nursing respondents, seemed related to the perception that the elimination of exclusive jurisdictions was a 'done deal.' In fact, this perception was verified by the government respondents who indicated that although proposed changes to the legislation were still under discussion with the professional groups, the proposal to eliminate exclusive practice jurisdictions was unlikely to change substantially. Thus, the nursing discipline, as did others, did not view the proposal of alternate models as a useful exercise.

With the exception of revisions to the disciplinary process, nursing respondents wished to retain the existing *Nursing Profession Act* inclusive of the exclusive scope of practice. In their view, exclusive scopes of practice did not generate the barriers to manpower utilization which the government and employers claimed. In fact, it was their perception that solutions to barriers between professions did not reside in policy alternatives but rather in the need for improved cooperation and collaboration between groups, something that could not be legislated.

The context in which nursing respondents voiced their opposition to the proposed change was significant. First, exclusive professional legislation had always been regarded by the nursing profession as the ultimate symbol of success in the achievement of professional status. Thus, the proposed change was seen as a loss of professional identity, the loss of a distinction which had been accorded other prestigious groups and an attempt by government to 'dismantle professions' (NP3, p. 24). Superimposed on what was already viewed as a significant professional challenge was unprecedented unemployment in the nursing labour force. It was a time when health care budgets had been markedly reduced, with a large number of nursing positions eliminated, re-classified as part-time positions, or reportedly converted to licensed practical nurse positions. Thus, it was not a cheery time for the nursing profession, nor one in which respondents were likely to be supportive of policies which they interpreted as furthering the utilization of less qualified workers.

Government respondents had been instrumental in various phases of the proposed changes and were committed to this policy direction. In their view, exclusive practice acts had been 'fashionable' in the 1980s but no longer served changing public needs. The number of health groups pressing for regulation, all of whom overlapped in some way with those having established exclusive jurisdictions, had steadily increased. And employers were frustrated by professional regulations which limited what they perceived as more efficient utilization of manpower in the face of dwindling operating funds. In grappling with this situation, the choices were two. One choice was to retain existing legislation and introduce exemptions, an approach which had proved to be unacceptably cumbersome. The second choice was to revise the legislation in keeping with what appeared to be the most contemporary means of eliminating artificial professional barriers, that being the replacement of exclusive jurisdictions with restrictions on the performance of specific activities. Thus, for the government respondents, the latter scenario was the preferred alternative.

Public respondents did not offer alternatives to the proposed legislation. This response was perhaps not surprising in that this group did not have a detailed knowledge of the proposed legislation. However, their view was that certain principles be reflected in whatever legislation was implemented. That is, in the future:

- professional associations needed to be much more attentive to the continuing competency of their members rather than to protection of professional 'turf';
- interdisciplinary, educational programs seemed to offer greater potential for collaboration between professional groups than a succession of regulations;
- legislation needed to be flexible, allowing the public to make choices amongst a variety of competent practitioners; and
- the utilization of health manpower must ultimately be connected to funding allocations.

In referring to the often voiced limitations of fee-for-service funding schedules, one of the respondents seemed to summarize the public respondents' view, "With different methods of reward and incentives, the collaborative team process will commence" (PP3, 13). Thus while this group was not able to provide an alternate model of legislation, they did identify principles on which any forthcoming legislation should be based.

Anonymity of Respondents

In gathering interview data, a common dilemma is how to preserve the confidentiality of respondents, yet provide the reader with sufficient biographical information to establish the credibility of respondents. Since most of the participants requested anonymity, this request was respected and applied to all participants. However, the dilemma remained as to how to protect participant identity by association. Since all of the interviewees were well known [prominent] in either the nursing or public service community and could be easily identified in a biographical description, it was decided that a general description of participants would provide some background information, yet minimize participant identity.

Focus on the Nursing Profession

In establishing limitations to the study, the nursing profession was chosen as the primary focus for a number of reasons. First, the nursing profession is the largest of the health professional groups, and the group which the public, in accessing health services, is most likely to encounter. Second, the researcher was directly involved with the Alberta Association of Registered Nurses at the time their exclusive practice legislation was enacted. Third, unlike other professional groups, nurses did not use the exclusive nursing legislation to challenge intrusion by other disciplines. However, although the decision to focus on one of the health professions resolved the potential study magnitude of including the thirty-one health professions, another challenge emerged. The premises on which health profession legislation is based apply to all professional groups. Thus to restrict discussion to only one discipline reinforces the separateness of professional groups, particularly at a time when the primary aim of legislation changes is to minimize 'turfdoms' and promote greater interdisciplinary cooperation. In fact, although the research questions focused on the nursing profession, most of the respondents had difficulty maintaining this focus, seemingly more comfortable in providing an 'armchair' perspective on all health professions. Therefore, the data collection and analysis phases of the study focused on the nursing profession. The concluding reflections are a compilation of background data, some of which specifically relate to the nursing profession, while other reflections are generic to all health professions.

REFLECTIONS ON THE JOURNEY

The formidable task of summarizing a dissertation is often equated with development of some sort of a grand synthesis. From the profusion of discussions, observations, insights, beliefs, digressions and arguments that inevitably arise from the complexities of health profession legislation, I am expected and compelled to create order, to somehow fit all the pieces into a coherent and intelligent design. Such a task is not only far beyond my capacity but would also be inconsistent with the spirit of the subject of my investigation. For perhaps the most remarkable aspect of this endeavour has been the discovery that participants in this journey agree, tacitly, that their world is a complicated and often confounding place, that most truths are partial or contingent, most research findings conditional, and that valid generalizations are hard to come by and harder still to sustain.

Therefore, instead of a grand synthesis, I propose a series of principles or statements which, at best, provide a partial rendering of what is a complex and fascinating subject. However, an important caveat applies to all the statements. While these statements reflect, to a greater or lesser extent, consensus amongst contributors in the field of health profession regulation, they are not intended, in this final analysis, to be conclusive. They are more accurately characterized as a collection of scholarly reflections addressed first, to all health professions, second, to the nursing profession and lastly to policy-makers.

TO YOU, THE HEALTH PROFESSIONS

In Canada, many of the health professions have been delegated legislative authority for a system of self-regulation that substantially influences who may provide service, the manner in which service is provided, who may receive service, and the nature of the service received (Rose, 1983, p. 104). This authority, widely accepted as a necessity to protect a relatively uniformed public from incompetent or unethical practitioners, has been linked with uncritical public esteem, significant influence on the content and the context of practice, and economic rewards less dependent on the marketplace than other occupations (Freidson, 1983; Ostry, 1978; Gross, 1988). Although health profession legislation has served the public and the professions well in the past, it is widely regarded as out of step with today's health care needs and expectations (Health Professions Review Committee, 1990; Manitoba Law Reform Commission, 1994; Alberta Health Workforce Rebalancing Committee, 1994; Pew Health Professions Commission, 1995).

Several factors have come together in the last decade to bring about an emerging public policy focus on the regulation of health professionals: rising health care costs, increasing consumer demand for choice in health service and participation in policy development, increased pressure for practice accountability, and charges of professional self-interest and monopolistic practices. Critics claim that professional regulations have not ensured quality service, licensing boards have failed to discipline unethical practitioners and actions against the unlicensed limit competition, not incompetence. In particular, licensing laws increase the cost of professional services, limit practitioner mobility, create manpower shortages, limit the use of paraprofessionals, impede advances in training and services, and restrict managerial and professional flexibility (Hogan, 1983; Gross, 1987, Manitoba Law Reform Commission, 1994; Pew Health Professions Commission, 1995). Proponents of regulation have argued convincingly that only individuals who have completed the requisite years of education and engaged in practice are capable of setting and enforcing appropriate standards for practitioners. They have also taken the position that since professionals are devoted to the best interests of the public, the delegated authority to set and enforce professional standards is justifiable. Professional groups have, therefore, been wary of government attempts to revise professional practice legislation, long considered the cornerstone which defines a professional body and the means by which a professional jurisdiction is legally and officially secured. They have in fact come to view self-regulation as a professional right rather than delegated authority to protect the public interest.

The concerns and criticisms have led to numerous provincial studies of professional regulation. (A detailed description of reviews undertaken in Quebec, Ontario, and Alberta is provided in Chapters 2 and 4.) All review committees have struggled with the need to reconcile self-regulation with government accountability, concerns over the monopoly potential of existing legislation, and the propensity for many of the disciplines to foster independent and exclusive practice areas when the functioning of the health system is dependent on coordination and cooperation. These reviews resulted in a number of changes, e.g., public representation on professional boards, separation of professional and union interests and revisions to professional conduct processes. However, for the most part, very little has changed in relation to the boundaries of professional practice or the allocation of functions among health personnel. What is evident from these reports is that health profession legislation has created an enormous challenge to governments to try and disentangle public interests from professional interests and to do so in such a way that decisions are politically palatable and economically sound (Boase, 1994, p. 15).

According to government sources, professional legislation in Alberta was not seen as a primary way to change the allocation of functions until the 1990s. Faced with the reality of financial constraints and the changing perceptions of the rationale for professional self-governance, governments have been compelled to assume greater responsibility for the direction of regulatory policy development. The most recent wave of regulatory reform, most evident in Ontario and Alberta, has deviated markedly from existing legislation. In Alberta, exclusive practice jurisdictions have been eliminated in recent draft legislation and replaced with restricted activities which may be performed by more than one category of professional.

Any single model of professional regulation is unlikely to attract consensus. Inevitably, any formulation of public policies directed at the professions will result in collectivities of diverging interests and spark emotional debate. The question is not whether there will continue to be professional autonomy in the absence of external controls; instead, the question is one of balance and degree in the reconciliation of both.

As all health professions progress through regulatory reform discussions in Alberta, the following are reflections from my own dissertation journey which may serve as guideposts to that important process.

Serving the Public Interest

Knowing that I risk the impatience of professionals, the often-repeated purpose of professional regulation warrants emphasis. The central tenet of professional regulation is to protect the public from harm caused by incompetent or unethical practitioners. Thus, the regulation of professions should only be undertaken when there is substantial evidence that risk of harm to the public will be reduced. It is not relevant that an occupational group is university-educated, has been in existence for some time, has developed its own code of ethics or that similar groups have obtained occupational regulation in other provinces (Manitoba Law Reform Commission, 1994, p. 8). In fact, professional regulation should not serve the interests of the practitioners at all, but should only be implemented when it is in the public interest to do so. In conclusion, the central question is: Is there a manifest need on the part of the public for protection from the improper performance of this service?

Provision of Cost-Effective Services

Within the realm of health care reform, there are no hidden agendas. The objective is to provide a continuously expanding health care system which is cost-effective. This does not mean holding cost as the paramount value in health care, but it does mean that the provider must work to utilize resources in a thoughtful and rational manner. Enhancing or diminishing the image or role of some health care professions is inevitable, but not a primary objective. The intent is not to ignore the trauma of job insecurity, interrupted careers, and revised roles; however, the primary concern must be with the recipient of health services and the agent who pays for these services (Abelson, 1997).

Exclusive Practice Jurisdictions

The model of exclusive scope of practice legislation has been known for its trophy value couched in public interest terms. This has been a much sought after form of legislation, almost always initiated by professions rather than the public whom it is intended to protect (Lieberman, 1978; Ostry, 1978; Pew Health Professions Commission, 1995). For professions with exclusive jurisdictions the achievement of this form of legislation is seen as the culmination of a series of predictable stages in the pursuit of professionalism. It is the origin of this pursuit that have led many critics to question whose interests are being served. In reality, this form of legislation has been used to recognize educational, ethical and professional achievements. The reward has been professional prestige and status commensurate with the acquisition of an exclusive jurisdiction.

Current statutes have granted broad exclusive scopes of practice to non-medical professional groups originally carved out of the exclusive practice area of physicians. In turn, more recently established professions have been compelled to carve out territories for themselves from the traditional groups. The result has been a number of apparently intractable 'border disputes' or 'turf battles' between related professional groups. Most frequently, the disputes are precipitated by one occupation attempting to usurp the monopoly power of another and the resistance of the challenged profession to threats of practice intrusion and economic interests. These scope of practice battles have come to look much like contests for more patients, more status and power, more independence, or, more money (Pew Health Professions Commission, 1995, p. 10). As one interviewee pointed out, the public has little interest in interprofessional battles over practice monopolies. Exclusive practice legislation has created unnecessary barriers to affordable, quality care. The need for a flexible, rational, cost-effective health system now calls for flexible scopes of practice that recognize the demonstrated competence and desire of various practitioners to provide the same or similar services. The implementation of a more level playing field has begun. The shift from an occupational to a task model of regulation meets this objective. As in any evolutionary process, better models or variations on existing ones will continue to emerge in the future.

Critics of this shift in focus charge that there is no evidence that the new model of professional regulation will be an improvement over the old model. In responding to this viewpoint, Sutherland (1996) suggested that

> Demands for extensive evaluation prior to the introduction of change can be merely a tactic to delay change. The status quo has been regularly proven to be ineffective, inefficient, and wasteful. New delivery arrangements should not be expected to be perfect. They only need to be better than what exists now. Changes should be introduced when they appear to be reasonable. (p. 123)

Task-Based Models of Regulation

The traditional approach to occupational regulation has been to license the entire profession. This has meant that the scope of practice has been composed of all of the tasks or services customarily associated with the discipline. These expansive scopes of practice generally exceed the intention of public protection. As was pointed out in the Ontario Health Professions Legislation Review (1990),

> The reality is that in no profession are all the activities engaged in by members potentially harmful. To prohibit . . . [others] from providing harmless services solely because they are within the scope of practice of a licensed profession maintains a useless fiction. (p. 14)

Exclusive scopes of practice have further restricted the performance of a typically broad array of services to specific groups of practitioners without any attention to the degree of harm inherent in specific tasks. It is the shift in focus from occupational models of regulation to task models of regulation which has become the centerpiece of contemporary professional legislation, particularly evident in Ontario and Alberta and under discussion in several other provinces. The task-based model of regulation deviates from traditional models in that the former is based on the premise that only a portion of a profession's services have the potential for harm if performed by unlicensed practitioners, and that these potentially harmful tasks can be safely performed by a variety of competent professionals. This thinking represents a significant shift in policy direction impacting on all health professions and seems to offer greater potential in reducing the barriers between practice jurisdictions. In attempting to collapse the central issue of professional regulation into one guiding question, that question would likely be, "What is the minimal amount of regulation that would protect the public?"

Potential of Harm to the Public

Professions who argue against the transfer of functions to alternate providers usually do so on the basis of potential harm to the public. As the Law Reform Commission of Victoria, Australia (1988) pointed out, all services provided by health practitioners involve risk. This is not itself a reason to regulate an activity or prevent an alternate provider from performing a health service. Only where it can be shown that there is an unacceptable degree of risk are regulatory controls justifiable. Thus, substantive evidence of potentially unacceptable risk includes the following factors: the likelihood of its occurrence, the significance of its consequences and the number of people threatened (p. 8).

Proliferation of New Professional Groups

Many new health professionals and paraprofessionals have joined the workforce over the past decades. This proliferation of health groups has resulted from increased specialization, technological complexity, increased educational requirements, and the professionalizing tendencies of occupational associations (Boase, 1994). The magnitude of this increase is evident from the number of groups which have gained official professional status in Alberta. In 1983 in addition to the fourteen professions with free-standing legislation, five additional groups (i.e., respiratory technology, nursing assistants, rehabilitation practitioners, acupuncturists, and hearing aid practitioners) were designated under the *Health Disciplines Act*. Ten years later, a total of fifteen groups had been designated under the same Act. It is also noteworthy that more than half of those seeking designation were unsuccessful (Health Disciplines Board, 1983 through 1995). As some of the non-traditional practitioners (i.e., herbalists, massage therapists, reflexologists) continue to gain in popularity with the public, it is probable that they too will seek regulatory status. In achieving recognition as a designated discipline, all of these groups will be required to also 'carve out' a practice area within a system of exclusive practice areas which does not recognize the possibility of overlapping scopes of practice based on demonstrated competency. For the most part, professional recognition has been hard won because of 'turf battles' that arise when any discipline attempts to advance into an exclusive jurisdiction. The need for accessible and cost-effective health care calls for much more flexible scopes of practice which recognize that different types of competent practitioners may provide the same health services (Pew Health Professions Commission, 1995).

Changing Professional Roles

The roles of health care providers have changed dramatically and will continue to do so in the future. Many factors contribute to these changes: technological developments, patterns of physician practice, cost-constraints, public attitudes, manpower shortages, method of payment, policy direction, political pressure, organizational change, patient needs, skill acquisition, insured services, and more. None of these factors are singularly contributory. Roles change gradually in response to societal circumstances.

These role changes invariably spark challenges from those who fear a loss of control over a practice area. The nature of the concern is usually couched in terms of potential harm to the public and is often based on the assumption that alternate practitioners are not competent to perform whatever service or task is being advanced. There is sufficient information to put to rest some of these concerns, and to challenge professions on the factual nature of their charges. Studies have been done on pediatric practice (Lave & Lave, 1970), dental hygienists (Dolan, 1980; Evans, 1980), dental nurses (Boase 1994; Sutherland, 1996), physician assistants (Hogan, 1983; Young, 1988); and nurse practitioners (Spitzer and Kergin, 1971; Spitzer, 1978). The general conclusion from these studies is that alternative practitioners can provide the same quality of service at less cost.

On the other hand, professionals wishing to maintain existing scopes of practice often argue that no evidence exists to support the change process or that the outcome will result in a lower quality, possibly unsafe service. Many functions not formally evaluated beyond expert opinion have been successfully transferred from physicians to other disciplines. An example of this is the taking of vital signs. Changes in health care often outpace scientific conclusions. However, although research is of vital importance in the ongoing analysis of outcomes, lack of evidence should not be used to inhibit the implementation of changes which, in expert opinion, appear to be beneficial and reasonable.

The conclusion to be drawn is that many services can be provided safely by more than one type of professional. All professions object to seeing 'their' service being assumed by other practitioners. However, the use of the lowest cost practitioner who can deliver competent service should be the basis for service provision.

Supporting Evidence for Expansion in Scopes of Practice

While there is evidence that some tasks and services can be safely and cost-effectively transferred to alternate practitioners or performed by more than one type of professional, this is not sufficient argument to expand scopes of practice. In proposing to expand practice areas, there are a number of questions which professions need to consider: How will the public be better served by the addition of this function? If roles are expanded, how will professionals be trained and at what cost? How will professional associations ensure continuing competence of practitioners? How will an expanded practice area affect collaboration and cooperation between related professions?

A number of professions have demonstrated an interest in expanding their scope of practice to include some diagnostic procedures and prescription of drugs. In this regard there are a number of questions which professions must give careful thought to. Which services currently provided by physicians or other professionals could be safely transferred to less costly but competent practitioners? In what way would the public be better served if some members of your profession were authorized to prescribe drugs and order laboratory and x-ray tests? Who should be authorized to perform these functions? How would the transfer of this function impact on health care costs? How would continuity in patient care be maintained? How would the coordination of the patient's health care be maintained? The answers to many of these questions are often not clearly definable. However, the overall objective in providing additional or altered services must always be in relation to the public, not professional interests.

In conclusion, health practitioners continue to enjoy remarkable professional freedom. By and large this professional independence has served the public and individual patients well, but at the expense of escalating costs and declining responsiveness to consumers. The goals and rules of competition between competing professions are changing in fundamental ways. The symbols of professional status are still powerful but less so than in the past. Health care has moved into an era of limits on professional freedom wherein professional decisions will be increasingly challenged by competing professions, consumers, and payers. Of particularly concern will be the appropriateness of service provision, by whom and at what cost (Pew Health Professions Commission, 1995).

In the emerging health care system, contests over exclusive rights to large fields of practice are disappearing. With the proposed elimination of exclusive scopes of practice, the reconstructed playing field will be more accessible to all professionals than at any other time in the history of health profession regulation. Such an environment will be supportive of shared professional responsibility and accountability for patient care (Storch, 1994). The professions which will thrive will be those whose services are competently delivered, well managed and economically accountable. It will be prudent to concentrate on working with, not against, those who fund health services for it is this group, more than any other force, who are questioning the traditions of professional dominance and pushing for a more flexible approach. Light (1988) has pointed out that deprofessionalization in the form of de-licensing is unlikely, despite what he regards as barriers to the allocation of personnel created by the 'crazy-quilt of licensing regulations' (p. 218). The preferred alternative, which is in the ascendance, is the recognition that provider groups have overlapping competencies enabling providers and purchasers the flexibility to manage how best to provide services and by whom. Thus the restrictively broad sweep of exclusive practice jurisdictions as an obstacle to recognizing the competencies of other practitioners and preventing cost-effective care is likely to weaken or disappear in the coming years.

TO YOU, THE PROFESSION OF NURSING

Nursing leaders have been at the forefront of legislative reform since 1916 when the discipline of nursing gained official status as the Alberta Association of Graduate Nurses and legal status through the *Registered Nurses Act* in the same year. In the ensuing years, the nursing profession embarked on a journey to full professional status including defining an area of practice, establishing standards of practice and education, expanding the educational base, claiming an area of expertise and training ancillary workers (Myskiw, 1992). College and university programs emerged, apprenticeship training was transformed into academically-based programs, entrance requirements continued to be upgraded, and unionized activities became an entity separate from the professional association.

The underlying motivation for many of these professional pursuits has been the need to emerge from under the thumb of hospital and medical dominance and to establish a nursing practice area distinct from physician practice areas (Coburn, 1993). It was this prevailing ideology, along with the related desire for mandatory registration which prompted three years of intensive lobbying and consultation, culminating in the addition of mandatory registration and an exclusive scope of practice clause to the renamed Nursing Profession Act in 1984. For the nursing profession, there are probably few other events which have been more significant to the achievement of official professional status than the passage of this legislation. As members recalled this historic time, there was a sense of achievement throughout the membership. As one interviewee described the response, "It gave nurses a sense of pride in their profession, . . . and I think it went a long way to propel nursing forward" (NP7, p. 2).

Indeed, the enactment of exclusive nursing legislation was an accomplishment. Although critics puzzled over the apparent contravention of prevailing provincial health policy, this landmark legislation was widely perceived by external policy analysts to be an impressive interest group victory, giving Alberta nurses the first exclusive practice act in Canada (Boase, 1994). It had been a time in Alberta when the political environment was opportune. Nurses enjoyed a good deal of public support, support from a resource-rich government as yet unencumbered by any apparent need for financial constraint, advisement from an influential nurse and member of the governing Conservative Party caucus, and a group of influential employers who saw a means to justify their desire for all-RN staffing. It was also, as one respondent pointed out, a 'fashionable' form of legislation prevalent in Alberta in the 1980s.

From its inception, exclusive nursing legislation was different from that of other free-standing professions. Because a much sought-after distinctive description of nursing practice had eluded the nursing community, the resultant exclusive scope of practice did not restrict the practice of other professionals. Furthermore, any intention to do so would have been thwarted by exemptions existing in other legislation and a government-initiated discretionary clause exempting individuals from mandatory registration if it was in the public interest to do so [Nursing Profession Act, Sec 1(4)]. Thus, as Boase (1994) described it, it was an example of legislation passed in response to vociferous and tenacious interest group input, largely in response to professional not public interests, and one in which "everyone got what they wanted" (p. 98). The nursing profession had the added prestige of a statute that granted a license, an exclusive scope of practice and mandatory registration, but a caveat had been included to protect the potential dislocation of other health professionals and allow government discretion.

The number of groups pressing for recognition has steadily increased. There are currently twenty-nine health professions regulated under fifteen statutes of which eight are exclusive statutes. Despite this expanding 'system' of professions, the structure of legislation has remained relatively unchanged from the pre-1945 era when the few existing health disciplines, namely medicine, dentistry, optometry and nursing, were engaged in independent fields of practice or within a defined subordinate role (Lomas & Barer, 1986). From the perspective of today's health care system, reform was inevitable. All of the nursing respondents attributed the proposed changes in legislation to a common denominator of cost reduction. Indeed, regulatory reforms *are* economically driven as a result of a collection of factors which governments face: barriers to the utilization of a variety of competent practitioners, unproductive turf disputes, a cumbersome system of legislation, a poorly coordinated system, inability of the public to select health services of their choice, an emerging and popular alternative health system, and a growing public suspicion that health profession legislation provides disproportionate benefits to professions rather than the public whom it is intended to serve (Young, 1988; Pew Health Professions Commission, 1995; 1997). Governments, the consumer public and professionals are in a process of renegotiating their relationships. The central objective is to redesign a regulatory system which is flexible, efficient and, thereby, cost effective.

Over the years, exclusive nursing legislation has remained symbolic of the ultimate professional achievement, that of a self-governing body with ownership over a distinct area of practice. And, as one interviewee described it,

> There are all kinds of pride and cultural things that have built up around having an exclusive scope of practice. . . . Many of our members hold that exclusive scope of practice dear because it is an achievement for nursing, because it's almost like an icon or a symbol of professionalism. (NP3, p. 3)

Perhaps as a reflection of these views, many of the nursing respondents argued for the retention of exclusive nursing legislation on the basis that it provided a professional identity and was non-restrictive of other health disciplines. While there is some truth to this argument, retaining an exclusive jurisdiction for one professional group would be an untenable policy direction. The need for accessible and cost-effective health care calls for flexible scopes of practice which recognize that different types of competent practitioners may provide the same health service. As one of the nursing interviewees commented, maintaining a competent workforce in all of the professions was the critical factor which she predicted would become the central force in protecting the public and a more viable alternative to the pursuit and protection of exclusive jurisdictions (NP4, p. 23).

As the nursing profession moves forward along the path of health profession legislation reform there are a number of reflections formulated as part of my own journey which may provide some assistance to nursing leaders. The reflections addressed to Health Professions are inclusive of the nursing profession. The following reflections are specific to the nursing profession.

Elimination of the Nursing Exclusive Scope of Practice

The traditional model of exclusive professional legislation in which all services provided by members of an occupation are similarly regulated is out of date with current realities. Contemporary health profession legislation shifts the regulatory focus from broad exclusive jurisdictions to control of specific tasks which have a high probability of being harmful to the public. The significance of this shift in focus is that while there are a number of tasks which can be competently performed by licensed practical nurses and other disciplines, there are also services which nurses can assume, most notably the nurse practitioner role, which have been restricted by exclusive legislation. As professional practice domains continue to change in response to patient needs, all professionals should be allowed and encouraged to provide services to the full extent of their current knowledge, training, experience and skills without the encumbrance of transgressing traditional exclusive practice jurisdictions. A regulatory system that has as its priority quality care, while eliminating restrictive scopes of practice, would not only allow practitioners to offer the health services they are competent to deliver, but would be more flexible, efficient, and effective (Pew Health Professions Commission, 1995). However, such a regulatory system is only possible if payment structures are also revised in relation to changes in roles. If current payment structures are maintained, proposed changes to health profession legislation are likely to have little effect on the reallocation of manpower.

The Struggle to Distinguish the Practice of Nursing

A great deal of energy has also been directed at defining a nursing scope of practice as distinct from the medical scope of practice. Under traditional legislation, this differentiation was important to avoid the necessity of physician approval for any activity construed as a 'medical act.' Timeless discussion of "What is nursing?" or "What constitutes nursing care?" particularly as it is differentiated from medical care, will become much less important in the future as contemporary legislation acknowledges overlapping practice based on demonstrated competence, making it possible for nurses (and other disciplines) to expand their scope of practice without physician approval. This new model of professional legislation is cause for optimism for the nursing profession. In essence, the way is clear to redirect attention from the definition of nursing to the future of nursing.

In addition to differentiating nursing care from medical care, nurses have struggled with what constitutes the uniqueness of 'nursing care' and how to interpret it to the public. The challenge is to use understandable language to clearly describe professional functions to the lay public. Terms such as health, illness, diagnosis, treatment, prevention, health, injury, and health information are descriptive words which are familiar to the public and describe what every nurse does. In contrast, phrases such as 'ethic of caring' are difficult to define and more difficult to explain.

Role Expansion in a Cost-Conscious Environment

Expanded and specialized roles have been discussed and promoted by the nursing community for decades. During this time period, evidence has accumulated which concludes that somewhere between 30% and 70% of physician tasks can be performed safely and cost-effectively by nurses without detriment to health outcomes (Sutherland, 1996). With the elimination of exclusive practice jurisdictions, nurses would be legally able to provide a broad range of health services without physician approval. However, while provincial laws are a prerequisite to expansion of nursing roles, they are not the only factor. The battleground over expanded practice is not primarily a matter of qualifications, legalities, public benefit or cost-effectiveness. The issue is money. If nurses (or any other practitioners) are seeking expanded roles in anticipation of incomes similar to physicians now performing those roles, role expansion is unlikely to be supported by government. If income levels are reasonable, and practitioners seek expanded scopes of practice for the purpose of job enrichment, greater job satisfaction and opportunity for career advancement, and if physician dollars can be transferred along with functions, governments are much more likely to be interested (Sutherland, 1996).

The addition of advanced skills such as ordering medications and ordering and interpreting diagnostic tests which nurses and other practitioners wish to have included in their scope of practice are likely to have cost implications. As nurses and others pursue expanded scopes of practice, attention must be given to the cost-benefit of proposed changes. It is not acceptable to propose expanded scopes of practice without attention to how additional practices can be paid for. This is not to suggest that answers are easily formulated. These are largely unexplored areas in which the questions are numerous including: Which services can be cost-effectively transferred to another discipline? How should expanded scopes of practice be paid for? If additional services are insured, at what income levels and at what levels of function do nurse practitioners or others with extended roles cease to be cost-effective? What are the initial and continuing educational costs associated with the performance of advanced practices? At what point does the cost of expanded services outweigh patient benefit? How do payment schedules affect the ability of government to adjust manpower utilization? The theme of this discussion also prompts a need for greater attention to research in the area of nursing economics, particularly in relation to cost-benefit research conducted from a multidisciplinary perspective.

Advanced Practice and/or Advanced Degree

For several decades, nursing educators have emphasized the importance of degree preparation, particularly master's and PhD level, as an accepted prerequisite for advanced or specialty practice. However, as one interviewee pointed out, expanded roles and advanced educational credentials are beyond the reality of many nurses. Sutherland (1996) has placed the majority of nurses within the following perspective:

> Expanded roles (namely nurse practitioner or clinical nurse specialist roles) will bring very few changes to the working lives of at least 90% of nurses. . . . It is both necessary and unavoidable that most nurses will, in the future, continue to practice nursing in much the same way as it is currently being practised. (p. 65)

This is not to suggest that the status quo will be maintained. However, by equating advanced or specialized practice with degree attainment, one interviewee pointed out that a very large percentage of nurses are left out. There is a need for greater emphasis on advanced specialization and recognition of existing specialized skills without necessarily equating advanced skills with advanced degrees. Nurses have already established competence in such specialty areas as dialysis, palliative care, neonatal and cardiology, and could contribute further in these areas through the addition of minor surgical procedures and diagnostic procedures e.g., cystoscopies and PAP smears, now performed by physicians. (See Decter, 1994; and Sutherland, 1996, for detailed discussions in this area.) With the elimination of physician exclusive practice areas, nurses can no longer be perceived to be trespassing on physician turf. Specific tasks can be easily costed in such a way that the transfer of functions (provided funds are also transferred) could provide convincing evidence of the potential for cost reduction; and many practising nurses have the basic skills which could be honed into a narrowed specialty practice without the pressure (or the necessity) of having to complete an advanced degree. This is a legitimate means of maintaining competency, optimizing lateral career transitions and enhancing job satisfaction.

Future Strategies

The future of nursing will be related to the extent to which the nursing profession is effective in influencing public policy. Nursing faculties, practitioners, and students often express strong and diverse views which are not always easily understood. Nurses need to speak more forcefully and effectively than they have in the past. As Michael Decter (1994), former Deputy Minister of Health in Ontario, projected in his book, *Healing Medicare*: "Nursing organizations are going to have to be aggressive, not simply about opposing changes which they view as detrimental to their members, but in recommending constructive alternatives" (p. 118). Opposition to proposed change furthers no-one's agendas, unless accompanied by constructive alternatives. In this regard, the selection of strategies must reflect the needs of consumers, communities, other professionals and governments. Recommendations must be detailed, credible, practical, constructive and accompanied by a realistic implementation plan. Policy-makers can not be expected to respond to proposals which increase costs, protect professional monopolies, and are impractical to implement.

In Conclusion

The decade of the nineties has been a turbulent one for the nursing profession, as traditions of professionalism are challenged. All professions face uncertainty as roles change and professional boundaries become blurred. For some, "the intense scrutiny and dramatic change now bombarding our social and health care systems elicits fear and protectionism" (Sutherland, 1996, p. 151). Alternatively,

> it is a time of opportunity; a time to set a new course through strategic planning; a time of exploring uncharted frontiers of the future as we pursue a new vision, a time to exercise confident leadership in making our preferred future a reality. (p. 151)

TO YOU, PROVINCIAL GOVERNMENTS AS POLICY MAKERS

Governments hardly need to be reminded that measures to reallocate functions among health personnel and establish alternatives to fee-for-service funding have been on their agendas since at least the late 1960s. With the introduction of the national health insurance system, governments recognized the need to reconcile the insatiable drive of occupations in their pursuit of professional status and a burgeoning health workforce responding to an increasingly demanding public, both of which have prompted continuous fiscal concerns (Tuohy, 1992). Although the recommendations from prolific commissions and taskforces reiterated the themes of preceding reports, resultant policies have been non-comprehensive, changed only incrementally from those already in existence (Weissert & Weissert, 1996). Government attempts to revise legislation have had virtually no effect on the allocation of functions among health care personnel as professional groups pursued and succeeded in attaining broad exclusive jurisdictions (Ontario Commission on the Healing Arts, 1970; Dussault, 1978; Health Professions Legislation Review, 1989; Tuohy, 1994; Sutherland, 1997).

However, policy makers have not been unwilling cooperators to the delegation of governance matters to professions. Each of the primary professions have wide fields of specialized knowledge inaccessible to the evaluative purview of those who would judge the quality of the provider or the service. When faced with little opposition from a supportive public with unconditional regard for health professionals, and professional associations who advanced convincing claims and strenuous lobby efforts in the interests of public protection, governments have welcomed the opportunity to delegate authority (and the financial responsibility) for the management of professional jurisdictions to the professional associations. In the absence of any third party interests in the financial or social aspects of the professional-patient interaction, and in the face of fairly uniform and accepted forms of service delivery, this seemed to be a reasonable policy solution. In fact, it could be described as an unusually satisfactory solution, wherein all stakeholders supported the policy direction. Thus, the interests and preferences of the primary professions, in the absence of government intervention became, by default, government policies (Tuohy & Wolfson, 1978; Lomas & Barer, 1986; Manitoba Law Reform Commission, 1994).

The policy environment surrounding health profession legislation has evolved considerably from this time of mutually satisfactory arrangements. Regulated health professions have proliferated with scopes of practice inevitably overlapping into traditionally exclusive jurisdictions. This has resulted in increasing conflict between professional groups and fundamentally different regulatory ideologies on the part of governments and health professions. As governments become pressed to find resolutions which are in the public interest, yet satisfactory to traditionally autonomous and powerful professions, the implications for government policy makers are many. As Trebilcock (1978) warned, "No single talisman of the public interest is likely to attract an overwhelming social consensus" (p. 14). In her summation of the nature of the undertaking, Boase (1994) concluded that

> governments must reconcile the conflicts among the disciplines, exercise their responsibilities by making regulatory decisions in esoteric areas where they have little or no expertise and where they must depend for advice on those being regulated, and be sensitive to the need for fiscal restraint. Governments must therefore attempt to make decisions in this very sensitive field that are at once politically expedient, scientifically sound and economically wise. It is certainly a challenge. (p. 15)

As government bureaucrats and politicians grapple with health profession legislation, the following are reflections on the future direction of that process.

Professions and Competence

Within the discourse of health profession legislation there is a point which is seldom given more than casual attention and one which rightfully should pervade policy direction. In relation to the volume of caseloads, the complexity of tasks, and the speed of technological change, health professionals provide exceptionally safe and competent services (Pew Health Professions Commission, 1995; Sutherland, 1996). Canadians can be relatively confident that they are unlikely to suffer irreparable harm as a consumer of even potentially high risk treatment procedures. Proponents of detailed regulatory controls will attribute this wide margin of safety to the central purpose of professional regulation. On the other hand, every profession has its charlatans and has, from time to time, been challenged by cases of incompetent or unethical practices despite regulation (Derbyshire, 1983; Gross, 1988). There is very little evidence in health research literature to suggest a correlation between professional legislation and the safety of the service provided. In fact, the only related study, undertaken some years ago, concluded that the age of a profession was the factor most related to the safety of service provided (Dussault, 1978). Thus, given the tenuous assumptions surrounding health profession legislation there are questions which are fundamental to this process: Which health-related groups should be regulated? How much regulation is necessary? and Does 'one size' fit all? That is should all professions have the same degree of specificity in regulations? Although the answers to these questions are of necessity largely based on expert opinion, the questions are no less important in the administration of this policy area.

Reflections on Shifts in Health Profession Policy

There are three themes which have emerged from this research study which have implications for policy direction. These three themes are: First, professional self-governance should be restricted to those technical aspects of the profession's practice which bear directly on the competence of the practitioner. Second, without alterations in existing payment structures it is unlikely that the allocation of professional functions will change significantly under the proposed Health Profession Act. And, third, governments are being admonished to assume more, not less, authority for professional regulation. Each theme is discussed separately although any measure of success is dependent on the interrelatedness of all three.

Alterations in Governance Structures

Protection of the public interest has always been the cornerstone on which professions have been delegated the responsibility for self-governance. This responsibility has evolved to include not only control over the technical content of the discipline, but also the broader context within which the practice occurs. To a large extent, the professional governance system based on the individual public interest, i.e., the quality of care provided to a patient, has been a powerful determinant of manpower and fiscal policy development. However, as governments developed increasing interest in the consumption of aggregate services and the distribution and roles of providers, it was apparent that in addition to the concern for the provision of quality care to individuals, there is also a concern for the quality of care provided to populations. This collective public interest, described by Lomas and Barer (1986), is focused on the efficient use of resources allocated across populations. It is their thesis that self-governance should be restricted to those technical aspects of the professional practice that bear directly on the competence of the practitioner (p. 267). All other responsibilities, including remuneration policies and organizational and distributional issues should be under the direct control of government policy-makers. It is this group which is the representative of the collective public interest and the repository of composite information unavailable to the professions. In essence, the information asymmetry has reversed, wherein governments, rather than individual professions, are more likely to possess efficiency information which is neither available to nor sought by nor consistent with the goals of the professions.

Revisiting Fee-for-Service Payment Structures

While the shift to task-based legislation is a significant and encouraging policy direction, *it is not sufficient* for the reallocation of resources in the delivery of health care. If there is one major theme running through this study and through related literature it is that

> leaving the current system of fee-for-service payments to private practices as the dominant combination of financing and organization is unlikely to result in the desired configurations, even in the presence of changed regulatory legislation and with the requisite mix of trained personnel available. (Lomas & Barer, 1986, p. 269)

These are not new or recent revelations, nor are they unknown to government bureaucrats and politicians. The unavoidable truth, which is also known, is that governments have not acted largely for political reasons. Provincial bureaucracies have been willing to accommodate the professional and economic interests of the medical profession, and avoid confrontation unless absolutely compelled to do so (Manga, 1993). Within the fee-for-service structure there is no incentive for physicians to endorse the utilization of alternate practitioners. Without alternate models of remuneration, it is unlikely that much will change in relation to reallocation of functions, particularly where alternate models of delivery result in the reduction of physician incomes (Hastings, Mott, & Hewitt, 1973; Decter, 1994; Lomas & Barer, 1986; Contandriopoulos et al., 1986; Manga, 1993).

Proactive Policy Making

Governments have, for some time, been admonished to assume much greater control of health profession legislation in contrast to the traditional reactive and piecemeal response to intense lobbying efforts of representatives of the professional associations (Commission on Civil Rights, 1968; Commission of Inquiry on Health and Social Welfare, 1970; Ontario Commission on the Healing Arts, 1970; Lomas & Barer, 1986; Manga, 1993; Boase, 1994). In the decades following the introduction of national health insurance, governments have attempted to reconcile the expectations of health care interest groups with the realities imposed by increased demand, and provision for insured services within the boundaries of limited resources. As health professions became more aggressive in pursing their professional and socio-economic interests, governments have been pressed into a more pluralist and reactive system of policy-making. More than once, the health care community has been described as chaotic (Commission on Civil Rights, 1968; Commission of Inquiry on Health and Social Welfare, 1970; Ontario Commission on the Healing Arts, 1970; Manitoba Law Reform Commission, 1994). If a conclusion can be drawn from these commissions, it is that, given a lack of coordination and cooperation in a thoroughly competitive professional community, the required degree of planning necessitates increased government control and intervention. Manga (1993) expressed a common sentiment when he noted:

> The cause of greater economic efficiency and equity are both more likely to be served by having the state take back increasing amounts of the power it earlier delegated to the dominant professionals, and to use that power to effect a shift toward less expensive forms of delivery, and away from doctor-dominated, technology-oriented, high-cost medicine. (p. 184)

In tracing the evolution of relationships among governments and health care interest groups in the Canadian provinces, Boase (1994) identified an emerging shift, particularly evident in the actions of governments in Ontario and Alberta, from a dependency on interest group pressure toward a concerted effort to plan the structure of the health care system. Cairns (1977) noted that "although societies can stand a great deal of chaos, the economic and social costs of contradictory policies generate pressures to minimize their incidence" (p. 724). Perhaps governments have reached a critical level of chaos in which there are compelling reasons to minimize the confusion, contradiction and equivocation. As Boase (1994) concluded,

> Governments faced with the need to make allocative decisions in a technologically complex, publicly funded, ~~and increasingly~~ expensive field, where there are high expectations of practitioners for professional career satisfaction and of the public for accessible and competent care, will be constrained to move toward proactive rather than reactive decision-making. (p. 175)

In Conclusion

The introduction of this contemporary health profession legislation has required enormous commitment on the part of government policy-makers. Not only is the undertaking intellectually challenging and politically risky, but it is compounded by the seemingly intractable and complex nature of inter-professional disputes (Boase, 1994). Furthermore, the shift to a task-based model includes a significant time commitment from inception to implementation during which time changes in government stakeholders are inevitable. As those involved with health profession legislation have come to understand, policy changes can only be viewed over a long time-horizon—at least a decade (Sabatier & Jenkins-Smith, 1993; cited in Weissert & Weissert, 1996, p. 243). Nor are problems 'solved' and taken off the policy map. Rather, as Wildavsky (1979) noted, once a solution is carried out, it creates whole new sets of issues, ensuring that no public problem ever really disappears (p. 34).

Given the nearly infinite array of impediments to policy change, the reader must by now wonder how reform ever occurs in health care policy. In fact, it is worth recalling that significant changes often do occur only after protracted delays. As Taylor (1978) reminded us, publicly financed health insurance has been on public policy agendas since 1919. Other large social policy programs —old age security, family allowances, and unemployment insurance programs also had protracted births. Smaller, incremental changes can and do occur at any time. Larger changes, however, which tend to affect strong entrenched interests, according to Van Loon (1986) will tend to occur under one, or preferably more, of the following circumstances: (a) an overwhelming public consensus; (b) the combination of a very strong concentrated interest and public apathy; (c) a major, well publicized foul-up or disaster, and preferably more than one; (d) a budgetary feast or a budgetary famine; or (e) when a single very powerful actor forces the issue (p. 471). However, one or more of these conditions is not sufficient. Added to the equation must be the passage of sufficient time for the policy concept to migrate from the realm of the revolutionary or the blasphemous to the accepted wisdom of the conventional (Ostry, 1978). Added as well must be a fortunate concentration of major actors. Thus, as Van Loon (1986) concluded at a symposium of health interest groups, "It is the combination of a supportive public, professional and bureaucratic environments and an alignment of the political stars that is most likely to produce significant reform" in the ongoing process of health profession legislation (p. 471).

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APPENDICES

APPENDIX A: INTERVIEW FORMATS

Interview Format for Registered Nurses

(Questions surrounding the history of the exclusive practice clause)

1. When did exclusive practice legislation come into existence?

2. How is the exclusive practice clause in the Nursing Profession Act interpreted to other health disciplines?

3. Who promoted exclusive scope of practice legislation and why?

4. What have been the expressed positions of stakeholders in relation to exclusive practice legislation and why?

(Questions about eliminating the exclusive practice clause)

1. Who are the principal stakeholders who are promoting a need for change in the legislation?

2. Why is the exclusive scope of practice clause being eliminated?

3. What factors are contributing to the increased demand for changes in regulations?

4. Is there a need to increase access to service delivery? (If not covered in above question)

5. What are the expressed positions of various stakeholders, e.g., LPNs, government, consumers

6. Why do you think stakeholders hold these positions?

(Questions pertaining to alternative solutions)

1. How did the proposed changes to legislation come about?

2. What does eliminating the exclusive practice clause mean to the Association?

3. Was the Association included in discussions regarding the elimination of the exclusive scope of practice clause?

4. Does the Association support the proposed changes? If not, why?

5. Can this issue be resolved?

6. Are there other policy solutions which would be more effective in resolving this issue and why?

7. What factors do you think will affect the resolution of this issue?

8. What effect do you think eliminating the exclusive practice clause will have on nursing?

9. What effect do you think it will have on other health disciplines?

Interview Format for Licensed Practical Nurses

(Questions surrounding the history of the exclusive practice clause)

1. How is the exclusive practice clause in the Nursing Profession Act interpreted to licensed practical nurses?

2. Who promoted exclusive scope of practice legislation and why?

3. What has been the positions of the PCLPN in relation to exclusive practice legislation and why?

(Questions about eliminating the exclusive practice clause)

1. Who are the principal stakeholders who are promoting a need for change in the legislation?

2. Why is the exclusive scope of practice clause being eliminated?

3. What factors are contributing to the increased demand for changes in regulations?

4. Is there a need to increase access to service delivery? (If not covered in above question)

5. What are the expressed positions of various stakeholders, e.g., RN's, government, consumers

6. Why do you think stakeholders hold these positions?

(Questions pertaining to alternative solutions)

1. How did the proposed changes to legislation come about?

2. What does eliminating the exclusive practice clause mean to your Association?

3. Was the Association included in discussions regarding the elimination of the exclusive scope of practice clause? Should they have been?

4. Does the Association support the proposed changes? Why?

5. Can this issue be resolved?

6. Are there other policy solutions which would be more effective in resolving this issue and why?

7. What factors do you think will affect the resolution of this issue?

8. What effect do you think eliminating the exclusive practice clause will have on the licensed practical nurses?

9. What effect do you think it will have on other health disciplines?

Interview Format for the Departments of Alberta Health, Alberta Labour, and Advanced Education and Career Development

(Questions surrounding the history of the exclusive practice clause)

1. Who promoted exclusive scope of practice legislation and why?

2. How is the exclusive practice clause in the Nursing Profession Act (and other free standing statutes interpreted to other health disciplines?

3. What have been the expressed positions of stakeholders in relation to exclusive practice legislation and why?

(Questions about eliminating the exclusive practice clause)

1. Who are the principal stakeholders who are promoting a need for change in the legislation?

2. Why is the exclusive scope of practice clause being eliminated?

3. What factors are contributing to the increased demand for changes in regulations?

4. Is there a need to increase access to service delivery? (If not covered in above question)

5. What are the expressed positions of various stakeholders, e.g., professionals, paraprofessionals, government, consumers?

6. Why do you think stakeholders hold these positions?

(Questions pertaining to alternative solutions)

1. How did the proposed changes to legislation come about?

2. Which stakeholder groups were involved?

3. What does eliminating the exclusive practice clause mean to the professional groups?

4. Was the Association included in discussions regarding the elimination of the exclusive scope of practice clause?

5. Does the Association support the proposed changes? If not, why?

6. Can this issue be resolved?

7. Are there other policy solutions which would be more effective in resolving this issue and why?

8. What factors do you think will affect the resolution of this issue?

9. What effect do you think eliminating the exclusive practice clause will have on nursing?

10. What effect do you think it will have on other health disciplines?

Interview Format for Public Representatives

These questions would follow a brief description of the status of professional legislation in Alberta.

1. Is there a need to regulate health professions?

2. Is the present form of regulation prohibitive to the public?

3. Is there a need to increase access to service delivery?

4. What factors do you think are contributing to the increased demand for changes in regulations?

5. Are there other means by which the public could have increased access to health services?

APPENDIX B: PERMISSION TO UTILIZE INTERVIEW DATA

Dear _________ .

As a graduate student in the Department of Educational Policy Studies, I am conducting research in the area of public policy and the regulation of health professionals. The purpose of the study is to determine if eliminating the exclusive practice clause from the Nursing Profession Act is a feasible policy solution to the perceived need to reduce barriers to the provision of professional services, or if other solutions are more desirable and feasible. Your willingness to share your knowledge and insights about the proposed changes to health profession legislation will contribute to my understanding of this policy change and assist me to complete the requirements for my EdD in Educational Policy Studies.

The opportunity to discuss the proposed changes with you is sincerely appreciated. I would like your permission to audio-record the interview to ensure that the data collected are both accurate and complete. The following conditions will apply to you as a participant in my research:

1. Participant will be fully informed of the nature and purpose of this study.

2. Participation is voluntary. Participants may withdraw from the study as their circumstances warrant.

3. Interviewees are guaranteed anonymity. Names of persons will not be identified in the final report. Participants will be referred to as a 'senior official' or as a 'representative.'

4. Interviews will be audio-recorded, and interviewees will have the opportunity to examine those portions of the recorded data which will be included in the data analysis.

5. Permission of the participants will be sought to include specific quotations in the final report of the study.

6. Data included in the final report will not be harmful or embarrassing to the participants.

Please indicate your understanding of the above conditions and your agreement to participate in this study by your signature below.

Signature ______________________